



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Mark Wesley Bailey

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-23-0771-01

Carrier's Austin Representative

Box Number 1

DWC Date Received

November 29, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 15, 2022	97750-FC	\$157.60	\$0.00
Total		\$157.60	\$0.00

Requestor's Position

"...Using the above formula the MAR is $$(62.46/34.6062) \times 33.16 = \59.85 . This billed for 16 units; therefore, $\$59.85 \times 16 = \957.60 . The carrier paid \$800.00. The difference between MAR and amount paid is \$157.60; and we are requesting this amount for reimbursement."

Amount in Dispute: \$157.60

Respondent's Position

"We have again reviewed payment for the services August 15, 2022, by Dr. Mark W. Bailey and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule. Per NPI 1578608070, which is found on the HCFA, the Primary Taxonomy for Mark W. Bailey is listed as 363LF0000X – Nurse Practitioner – Family."

Response submitted by: Liberty Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for FCE billing and reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 252 – The recommended allowance is based on the value for services performed by a licensed non-physician practitioner
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for physical therapy services performed in August 2022. Specifically, 97750 – FC. The carrier reduced the allowed amount based on reduction of non-physician practitioner.

Review of the submitted medical bill found License number DC60441TX and NPI number 1578608170. The NPI registry at www.npiregistry.cms.hhs.gov, found this license and NPI is associated with "Chiropractor." The insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guidelines.

2. DWC Rule 134.204 (g) states in pertinent part, FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1)

of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test;

DWC Rule §134.203 establishes the maximum allowable reimbursement as (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

DWC Rule 28 TAC §134.203 (b) (1) requires the application of Medicare payment policies applicable to professional services.

The Medicare multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day.

The MPPR policy allows for full payment for the unit or procedure with the highest Practice Expense (PE) payment factor and for subsequent units the Practice Expense (PE) payment factor is reduced by 50 percent.

Code	Practice Expense	Allowed Amount	Medicare Policy
97750	0.52	33.16/24.57	First unit paid at full rate, 2 nd through 16 th unit at reduced rate

The *MPPR Rate File* that contains the payments for 2022 services is found at <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

- MPPR rates are published by carrier and locality.
- The services were provided in Harlingen, Texas.
- The carrier code for Texas is 4412 and the locality code for Edinburg is 99.

The maximum allowable reimbursement based on carrier and location is found below.

- Code 97750 first unit allowable $33.16 \times 62.46/34.6062 = \59.85
- Code 97750 15 units allowable (MPPR reduction applies) $24.57 \times 62.46/34.6062 \times 15 = \665.19
- Total MAR \$725.04

3. The total allowable DWC fee guideline reimbursement is \$725.04 the insurance carrier paid \$800.00. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. The amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

March 30, 2023

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 TAC §141.1(d).**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.