



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Devin Pettiet

Respondent Name

Seabright Insurance Co

MFDR Tracking Number

M4-14-1739-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The first four visits were paid leaving the second two dates outstanding. SeaBright's claim that the pre-authorization was exceeded is obviously wrong and is easily discernible from the medical and billing records."

Amount in Dispute: \$476.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Pettiet failed to adhere to the certification request which approved 6 physical therapy sessions by exceeding the number of certified sessions."

Response Submitted by: SeaBright Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15 – 18, 2013	99211, 97140, G0283, 97110, 97010, 99213	\$476.00	\$476.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 747 – Per adjuster instruction deny as disputed or denied claim
 - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
 - 284 – No allowance was recommended as this procedure has a Medicare Status of 'B' bundled

Issues

1. Did the requestor receive required authorization?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent in their position statement says, “Dr. Pettiet failed to adhere to the certification request which approved 6 physical therapy sessions by exceeding the number of certified sessions.” The only evidence submitted with this was a screen shot showing a highlighted box that states,

“Inv/Rcpt Ref Chk Nbr Chk Date From Thru Billed Amount Payee/Rcpt Payer”
 “9878063, 1213311 05/09/13 04/09/13 – 04/11/13 439.00 272.77 Pettiet, Devin.”

This information does not support the respondent’s claim that authorized visits were exceeded.

Review of the submitted documentation finds;

- a. Notice of Certification dated 03/29/2013 from Paladin Managed Care Service
- b. Specific Treatment Plan Requested: 6 physical therapy sessions
- c. Authorization timeframe: 03/27/2013 – 05/27/2013
- d. Conclusion: Certify the request for a trial of 6 PT sessions as medically appropriate and within guidelines.

28 Texas Administrative Code §134.600 (I) states, “The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued.” The Carrier finds the services in dispute were prior authorized and the Carrier has failed to support their statement that services were exceeded. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states, “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Units	Maximum Allowable Reimbursement (TDI – DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price = MAR	Prior authorization received
April 15, 2013	99211	1	$(55.3 / 34.023) \times 19.12 = \31.08	Not required
April 15, 2013	97140	1	$(55.3 / 34.023) \times 28.56 = \46.42	yes
April 15, 2013	G0283	1	$(55.3 / 34.023) \times \$21.00 = \21.00	yes
April 15, 2013	97110	2	$(55.3 / 34.023) \times 30.48 = \$49.54 \times 2 = \$99.08$	yes
April 15, 2013	97010	1	Hot Packs not separately payable	
April 18, 2013	99213	1	$(55.3 / 34.023) \times 69.96 = \112.25	Not required
April 18, 2013	97140	1	$(55.3 / 34.023) \times 28.56 = \46.42	yes
April 18, 2013	G0283	1	$(55.3 / 34.023) \times \$21.00 = \21.00	yes
April 18, 2013	97110	2	$(55.3 / 34.023) \times 30.48 = \$49.54 \times 2 = \$99.08$	yes
April 18, 2013	97010	1	Hot Packs not separately payable	
		Total	\$476.34	

The total allowable charges are \$476.34.

3. The total recommended payment for the services in dispute is \$476.34. This amount less the amount previously paid by the insurance carrier of \$0.00. The requestor is seeking \$476.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$476.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$476.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

March 12, 2015

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

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

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