Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-07-1126-01
SADI Pain Center 2525 West Bellfort St Ste 120 Houston, TX 77054-5024	DWC Claim #: Injured Employee:
Respondent Name and Box #:	Date of Injury:
Texas Mutual Insurance Co Rep Box #: 54	Employer Name: SAMUELS GLASS CO Insurance Carrier #: 99F000041194502

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor has not submitted a Position Summary; however, the Requestor's rationale on the Table of Disputed Services states, "Not paid fair/unreasonable."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Respondent did not submit a response to the DWC-60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78240 is located in Bexar county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
04/26/06	97, 217, W4, 435, 891	72275-TC-59 ($78.66 x 125%)	1, 2	$98.33
Total Due:				$98.33

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

The Requestor withdrew CPT Codes 36000 and 99499 listed on the Table of Disputed Services; therefore, these CPT codes will not be a part of this review.

1. These services were denied by the Respondent with reason code "97 – Payment is included in the allowance for another service/procedure, 217 – The value of this procedure is included in the value of another procedure performed on this date" and "W4 – No additional reimbursement allowed after review of appeal/reconsideration, 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure, 891 – The insurance company is reducing or denying payment after reconsideration."

2. Per Rule 134.202(b), CPT code 72275 is not considered a component procedure to another code billed on the same date of service; therefore, per Rule 134.202(c)(1) reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $98.33 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

		05/30/07
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. §413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision, that is the subject of the appeal, is final and appealable. The Division is not considered a party to the appeal.

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