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 #: M4-07-1976-01
SADI Pain Center 2525 W. Bellfort St. Ste. 120 Houston, TX 77054-5024	DWC Claim #:
	Injured Employee:
Respondent Name: University of Texas System	Date of Injury:
	Employer Name: University of Texas System
Box #: 46	Insurance Carrier #: 06E0044

PART II: REQUESTOR POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary, taken from the Table of Disputed Services states in part, "Not paid fair/Unreasonable."

Principle Documentation:

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

PART III: RESPONDENT POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent Position Summary, taken from the Table of Disputed Services states in part, "W4/15=Epidurogram not included in the pre-authorization of the ESI."

Principle Documentation:

1. Response to 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
1/18/06	15, W4	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, set out the reimbursement guidelines.

CPT code 99499 was withdrawn by the Requestor on 5/08/07 and is no longer in dispute.

1. This dispute relates to procedure 72275-TC-59 and Respondent's denial of payment based upon, initial denial- 15 – "Pymt adjusted because submitted authorization no. is missing, invalid, or does not apply to the billed services or provider." Reconsideration denial – W4 – "No additional reimbursement allowed after review of appeal/reconsideration

2. Per Rule 134.600, preauthorization is not required for the service in dispute; therefore, per Rule 134.202(c)(1), reimbursement is recommended for CPT code 72275.

A Legal & Compliance referral will be made.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, §134.600

PART VII: DIVISION DECISION AND/OR 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:

	Scott Hansen	6/22/07
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.