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 Name and Address: SADI Pain Center 2525 W. Bellfort Houston, TX 77054	MFDR Tracking #: M4-07-3471-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Liberty Mutual Insurance Co Rep. Box # 28	Date of Injury: Employer Name: Todd Ford Management Inc Insurance Carrier #: 973436234

PART II: REQUESTOR'S 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. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary, taken from the Table of Disputed Services, states in part, "Bundled procedure per Medicare correct coding bundled to 62264."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
04/17/06	97, B377	72275-TC-59	1-2	$98.33
TOTAL DUE:				$98.33

PART V: REVIEW SUMMARY, METHODOLOGY AND/OR 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 reimbursement guidelines.

1. This dispute relates to procedure 72275-TC-59 (epidurography) and Respondent's denial of payment based upon, initial denial-"97 – Included in the allowance for another service/procedure." B377 – "This is a bundled procedure; No separate payment allowed. (B377)." Reconsideration denial was the same.

2. Per Rule 134.202(b), "CPT code 72275 is not bundled to any other code billed on the CMS-1500 submitted by the Requestor; therefore, payment of $98.33 ($78.66 x 125%) is recommended on CPT code 72275-TC-59.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code Sec. 413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202
28 Texas Administrative Code Sec. §133.307 (effective 12/31/06)

PART VII: DIVISION DECISION AND 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 the amount of $98.33 and accrued interest to the Requestor within 30 days of receipt of this Order.

Decision & Order:

	Scott Hansen	03/12/2007
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.