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 #: M4-07-3823-01 DWC Claim #: Injured Employee:
Respondent Name: City Of San Antonio Box #: 42	Date of Injury: Employer Name: CITY OF SAN ANTONIO Insurance Carrier #: 12141655

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, "Per Medicare fee schedule we are owed this amount."

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 position summary.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
10/12/06	97 / W4	36000-59	1, 2	$32.43
Total Due:				$32.43

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.

1. This dispute relates to CPT codes 36000-59 (Introduction Needle) denied on original EOB with reason codes "97 (Payment is included in the allowance for another service/procedure), and denied on reconsideration EOB with reason codes W4 (No additional reimbursement allowed after review of appeal/reconsideration)."

2. Per Rule 134.202(b), CPT code 36000-59 is not bundled to any other code billed on the CMS-1500 submitted by the Requestor.

3. Per CMS-1500, services were rendered in zip code 78240 which is located in Bexar County. The MFG MAR for CPT code 36000-59 in Bexar County is $32.43. Rule 134.202(c)(1) reimbursement in the amount of $32.43 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

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

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 $32.43 plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order:

		05/02/07
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.