Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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: SADI Pain Center 2525 West Bellfort St Ste 120 Houston, TX 77054-5024	MFDR Tracking #: M4-07-3898-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Co Rep Box #: 54	Date of Injury: Employer Name: PARENT CHILD INC Insurance Carrier #: 99D0000355846

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 were not paid."

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

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
11/08/06	97, 217, W4, 981	72275-TC ($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.

On 5/10/07, the Requestor withdrew CPT Code 36000 listed on the Table of Disputed Services; therefore, this CPT code 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, 891 – The insurance company is reducing or denying payment after reconsidering a bill."

2. Per Rule 134.202(b), CPT code 72275 is not integral to any other code billed on the CMS-1500 submitted by the Requestor; 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:

		06/11/07
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.