



**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 #: M4-07-4768-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  Liberty Mutual Insurance Co Rep Box #: 28	Date of Injury:
	Employer Name: BEELER PROPERTIES INC
	Insurance Carrier #: 973455235

**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 this amount is due."

Principle Documentation:

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

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Respondent's Position Summary: "Documentation attached is from the Medicare Correct Coding Guide showing our rationale for denial of code 72275 as billed with 62264."

Principle Documentation:

1. Response to DWC 60

**PART IV: SUMMARY OF FINDINGS**

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
08/18/06	97	72275-TC	1, 2	\$00.00
<b>Total Due:</b>				\$00.00

**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.

1. This service was denied by the Respondent on original and reconsideration EOBs with reason code "97 – This is a bundled procedure; no separate payment allowed."
2. Per Rule 134.202(b), CPT code 72275 is considered to be a component procedure of CPT code 62264. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. Therefore, per Rule 134.202(b) reimbursement is not 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 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 not entitled to reimbursement for the services involved in this dispute.

**DECISION:**

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.**