



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 #:	M4-07-4780-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: City Of San Antonio Rep Box #: 42	Date of Injury:	
	Employer Name:	CITY OF SAN ANTONIO
	Insurance Carrier #:	276476X1

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 due 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 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
10/20/06	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. These services were denied by the Respondent with reason code "97 – Payment is included in the allowance for another service/procedure" and "W4 – No additional reimbursement allowed after review of appeal/reconsideration."
2. Per Rule 134.202(b), CPT code 36000 is not considered a component procedure to another code billed on the same date of service; 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 \$32.43 plus accrued interest, due within 30 days of receipt of this Order.

ORDER:

05/21/07

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.