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 #: M4-07-5886-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Liberty Mutual Insurance Co Rep Box #: 28	Date of Injury: Employer Name: STAFF LEASING Insurance Carrier #: 949622938

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

Respondent's Position Summary: "Attached you will find a copy from the Medicare Correct Coding Guide which includes code 72275 as a correct coding edit for code 62311."

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
11/27/06	97	72275-TC	1, 2	$00.00
Total Due:				$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.

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. 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 62311. A modifier is allowed in order to differentiate between the services provided; however, the Requestor's CMS-1500 supports that this code was not billed with an appropriate modifier. 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.