



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: Health Care Provider Injured Employee Insurance Carrier

Requestor=s Name and Address: SADI Pain Center 2525 W. Bellfort #120 Houston, TX 77054	MDR Tracking No.:	M5-07-0634-01
	Previous Tracking No.:	M4-06-0705-01
	Claim No.:	
Respondent's Name: TEXAS MUTUAL INSURANCE CO, Box 54	Injured Employee's Name:	
	Date of Injury:	
	Employer's Name:	
	Insurance Carrier's No.:	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary (Table of Disputed Services) states, "Not paid Fair/Unreasonable".

Principle Documentation:

1. DWC 60 package
2. CMS 1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states, "Review of the records and the diagnosis codes supports that the facility charge (99499) and the epidurograph (72275) were for the same diagnoses and surgery as billed by the surgeon. There were NO separate procedures or sessions. The use of modifier "59" appears to be inconsistent with CCI edits, as no separate procedure, diagnosis, or session were documented."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
6-16-05	W4, 97, 891, 435	72275-TC-59	1, 2	\$98.71
	Total Due			\$98.71

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR 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.

In a letter dated 1-12-07 the Requestor withdrew CPT codes 72275, 99499, A4930 and A4641 billed on 6-16-05 which were denied for medical necessity.

On 9-27-05 the Medical Dispute Resolution submitted a Notice to Requestor to submit additional documentation necessary to support the charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the Requestor's receipt of the Notice.

1. The Respondent denied these charges as “W4-No additional reimbursement allowed after review of appeal/reconsideration,” “97-Payment is included in the allowance for another service/procedure,” 891-The insurance company is reducing or denying payment after reconsidering a bill,” and “435-Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.”
2. Services billed by SADI Pain Center rendered on 6-16-05 were on two separate CMS 1500s. One bill is for the technical component. The other bill is for the professional component. The Respondent cannot bundle two separate bills; therefore, payment of \$98.71 per Rule 134.202(d)(2) is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d), 413.031
 28 Texas Administrative Code Sec. §134.1

PART VII: DIVISION DECISION AND 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 \$98.71 plus accrued interest, due within 30 days of receipt of this Order.

Findings and Decision by:

03-30-07

 Authorized Signature

 Typed Name

 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.