Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Pedro Nosnik, M.D. 4100 West 15th Street, Suite 206 Plano, Texas 75093	MDR Tracking No.: M4-05-0349-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Royal Insurance Company C/o Cunningham Lindsey US, Inc. Rep Box # 11	Date of Injury: Employer's Name: Sage American, Inc. Insurance Carrier's No.: 7695084

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Fee issues…Compensable injury treated."

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Reports dated 09/25/03 and 10/28/03

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…Entitlement to Benefits…Extent of Injury…"

Principle Documentation:
1. Respondent's position summary
2. Explanation of Benefits
3. Report dated 09/25/03 and 10/28/03
4. Charles A. Popeney, D.O., Peer Review Report dated 07/14/01
5. Angie Cook, RN, CorVel Utilization Review Report dated 07/05/01

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)
09/25/03	E, R	99214	1	$92.30
10/28/03	E, R	99213	2	$59.00
TOTAL DUE				$151.30

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

1. Code 99214 for date of service 09/25/03 denied as "E—Entitlement to benefits" and "R—Extent of injury". Carrier reimbursed the Requestor $00.00. A Benefit Review Conference was held on 04/14/97. It was determined by the Commission that, "Agreement signed accepting blow to head as part of compensable injury". The diagnosis codes documented on the HCFA-1500 indicated treatment for 780.39 – convulsions. According to the treatment records provided, Medical Dispute Resolution has determined that the requestor treated the compensable injury; therefore reimbursement is recommended. The Requestor submitted medical records to substantiate the level of service billed. Per Rule 134.202, reimbursement shall be according to Medicare plus 125%. Medicare pricing is $92.30

($73.84 x 125% = $92.30). Therefore, reimbursement in the amount of $92.30 is recommended.

2. Code 99214 for date of service 10/28/03 denied as "E—Entitlement to benefits" and "R—Extent of injury". Carrier reimbursed the Requestor $00.00. A Benefit Review Conference was held on 04/14/97. It was determined by the Commission that, "Agreement signed accepting blow to head as part of compensable injury". The diagnosis codes documented on the HCFA-1500 indicated treatment for 780.39 – convulsions. According to the treatment records provided, Medical Dispute Resolution has determined that the requestor treated the compensable injury; therefore reimbursement is recommended. The Requestor submitted medical records to substantiate the level of service billed. Per Rule 134.202, reimbursement shall be according to Medicare plus 125%. Medicare pricing is $59.00 ($47.20 x 125% = $59.00). Therefore, reimbursement in the amount of $59.00 is recommended.

Therefore, it is the conclusion of the Medical Review Division that reimbursement in the amount of $151.30 is due the requestor.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202

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 in the amount of **$151.30**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

		01/27/06
Authorized Signature	Typed Name	Date of Order

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.