# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** (x) Yes ( ) No |
|---|---|
| Requestor's Name and Address<br>Dr. Pedro Nosnik<br>4100 West 15th St., Ste. 206<br>Plano, TX 75093 | MDR Tracking No.: M4-05-0873-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>Employers Insurance Co. of Wausau Box: 47<br>c/o Liberty Mutual Insurance<br>2875 Browns Bridge Rd.<br>Gainesville, GA 30504 | Date of Injury:<br>Employer's Name: Lubys Restaurants<br>Insurance Carrier's No.: 012062010566WC01 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 03/11/04 | 03/11/04 | 95903 | $32.92 | $32.92 |

## PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a Position Summary; however, the requestor's rationale on the table of disputed services states, "Per the EOB states' fee guideline MAR reduction". This claim was not paid according to the Dallas County fee guidelines. This is in box 32 on the HCFA. Fee Dispute."

## PART IV: RESPONDENT'S POSITION SUMMARY

The Respondents Position Summary states, "Please find attached explanatory EOB's which indicate reconsideration explanation – clm was overpaid on 95934 by $35.93 – which was therefore deduced when reconsideration processed."

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

Per Rule 133.304(b)(3) the insurance carrier may request a refund for an overpayment. Texas Workers' Compensation Commission rules do not allow for recoupment of overpayment of medical bills.

- CPT Code 95903 for date of service 03/11/04 denied as "F". Per Rule 134.202 reimbursement shall be according to Medicare plus 125%. Medicare pricing is $72.23 per nerve. The Requestor billed for 4 nerves; therefore, reimbursement should have been $361.16 ($72.23 x 4). The insurance carrier reimbursed the health care provider $325.24 leaving a balance of $35.92. The Requestor has asked for additional reimbursement in the amount of $32.92. Additional reimbursement in the amount of $32.92 is recommended.

## PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $32.92. 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 20-days of receipt of this Order.

**Ordered by:**

| Authorized Signature | Marguerite Foster<br>Typed Name | May 25, 2005<br>Date of Order |
|---|---|---|

## PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____