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 Dr. Pedro Nosnik 4100 W. 15th St., Ste. 206 Plano, TX 75093	MDR Tracking No.: M4-05-1395-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 17 Federal Insurance Company c/o The Hartford 300 S. State St., One Park Pl. Syracuse, NY 13202	Date of Injury: Employer's Name: Gaylord Entertainment Co. Insurance Carrier's No.: YBU80543

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			
06/22/04	06/22/04	92545-76, 92546-76 and 92547-76	$61.62	$61.62

PART III: REQUESTOR'S POSITION SUMMARY

Please find 3 EOB's recommending payment but this still was not paid according to the 2004 Fee Guidelines.

PART IV: RESPONDENT'S POSITION SUMMARY

Add'l pymts made 11/12/04. (1) test why billing (2)? Add'l payment made please see next page. CPT state electrodes not per electrode. Add'l reimbursement is not warranted.

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

The healthcare provider submitted an up-dated table on June 1, 2005 showing the insurance carrier paid all the disputed CPT Codes; however, some CPT Codes were not paid according to the Medical Fee Guideline.

- CPT Code 92545-76 for date of service 06/22/04. The insurance carrier paid a total of $44.65; per Rule 134.202(c) reimbursement in the amount of $51.50 is the amount that should have been paid; therefore, additional reimbursement in the amount of $6.85 is recommended.

- CPT Code 92546-76 for date of service 06/22/04. The insurance carrier paid a total of $88.93; per Rule 134.202(c) reimbursement in the amount of $104.54 is the amount that should have been paid; therefore, additional reimbursement in the amount of $15.61 is recommended.

- CPT Code 95247-76 (4 units) for date of service 06/22/04. The insurance carrier paid $50.16 per unit; per Rule 134.202(c) reimbursement in the amount of $59.95 per unit is the amount that should have been paid; therefore, additional reimbursement in the amount of $39.16 ($9.79 x 4) 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 $61.62. 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.

Or

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Marguerite Foster	June 3, 2005
Authorized Signature	Typed Name	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: _______________________