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.: M4-05-3579-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company C/o Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Walgreen Co. Insurance Carrier's No.: 4650177211

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Fee issue"

Principle Documentation:
1. Requestor's position summary
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Work Status Report dated 07/12/04
6. Office Visit Report dated 07/12/04

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Not related to compensable injury"

Principle Documentation:
1. Respondent's position summary
2. TWCC 60/Table of Disputed Services

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)
07/12/04	D	99213	1	$61.98
07/12/04	D	99080-73	2	$15.00
TOTAL DUE				$76.98

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 99213 for date of service 07/12/04 denied as "D—Duplicate Bill". Although the Respondent's position summary stated, 'Carrier disputed payment on the basis of a pending compensability…', the Respondent failed to file a TWCC-21 with the Commission disputing compensability or extent of injury in accordance with Section 408.027; therefore, the services will be reviewed in accordance with the Medicare Fee Schedule. Rule 133.307(j)(2) specifically states, 'The response shall address only those denial reasons presented to the requestor prior to the date

the request for medical dispute resolution was filed with the division and other party. Response shall not address new or additional denial reasons or references after the filing of the request. Any new denial reasons or references raised shall not be considered in the review.' Carrier reimbursed the Requestor $00.00. 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 $61.98 ($49.58 x 125% =$61.98). Therefore, reimbursement in the amount of $61.98 is recommended.

2. Code 99080 for date of service 07/12/04 denied as "D—Duplicate Bill". Although the Respondent's position summary stated, 'Carrier disputed payment on the basis of a pending compensability…', the Respondent failed to file a TWCC-21 with the Commission disputing compensability or extent of injury in accordance with Section 408.027; therefore, the services will be reviewed in accordance with the Medicare Fee Schedule. Rule 133.307(j)(2) specifically states, 'The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and other party. Response shall not address new or additional denial reasons or references after the filing of the request. Any new denial reasons or references raised shall not be considered in the review.' Carrier reimbursed the Requestor $00.00. Per Rule 134.202(e)(8) and Section 129.5(i)(2) reimbursement in the amount of $15.00 is allowed. Therefore, reimbursement in the amount of $15.00 is recommended.

Therefore, it is the conclusion of the Medical Review Division that reimbursement in the amount of $76.98 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
28 Texas Administrative Code Sec. §133.307(j)(2)
28 Texas Administrative Code Sec. §134.202(e)(8)

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 **$76.98**. 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:

Authorized Signature	Typed Name	02/02/06 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.