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.: M4-05-5705-01

TWCC No.:

Injured Employee's Name:

Respondent's Name and Address BOX #: 28
Employers Insurance Co.
c/o Liberty Mutual Insurance
2875 Browns Bridge Road
Gainesville, GA 30604

Date of Injury:

Employer's Name: Garden Ridge Corp

Insurance Carrier's No.: 197550109

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**			
11/06/04	**11/06/04**	**95904 (2 units)**	**$145.20**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a Position Summary; however, the Requestor's rationale on the table of disputed services states, "This is denied as Global this is a Fee Issue we billed for 4 units for CPT 95904 Insurance only paid for 2 units"

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent's Position Summary states in part, "Paid 2 units at 72.59 = $145.18 (One on the right side and one on the left side.) Denied 2 units global. Reimbursement is made per nerve not per branch of each nerve".

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

- CPT Code 95904 for date of service 11/06/04 denied as "G – X212 – This procedure is included in another procedure performed on this date." Per Rule 134.202(b) Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. Per the Medicare policy when multiple sites on the same nerve are stimulated these procedures can only be billed one time. Each procedure must be reported on a separate detail line. Report the first line without a –76 modifier. When using the same procedure code, report all additional lines with a –76 modifier and indicate if the service was provided on the same nerve or a separate nerve. Reimbursement is not 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 not entitled to (additional) reimbursement.

Decision by:

	Marguerite Foster	May 19, 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: ________________________