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 Pedro Nosnik, M.D., PA 4100 W. 15th St., Ste. 206 Plano, TX 75093	MDR Tracking No.: M4-05-6168-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 12 TASB Risk Management P.O. Box 2010 Austin, TX 78768	Date of Injury: Employer's Name: McKinney ISD Insurance Carrier's No.: 0250011031806979

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			
08/09/04	08/09/04	95904	$125.86	$125.86

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, "The insurance only paid for 2 units of this CPT code, we bill 4 units they have denied the additional units 'fee guideline MAR reduction'".

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a Position Summary; however, the Respondent's rationale on the Table of Disputes Services states, "Carrier previously stated the nerve tested was not a nerve recognized as reimbursable - Medial Plantar. Previously paid per schedule."

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

- CPT Code 95904 for date of service 08/09/04 – The Respondent reimbursed for two nerves and denied the other two as "F – Fee Guideline MAR Reduction, medial plantar not a reimbursable nerve." Per Rule 134.202(b) and (c)(1) and the Medicare Fee Schedule, reimbursement for the nerve conduction, amplitude and latency/velocity study is reimbursed for each nerve, the Medicare Fee Schedule does not specify nerves that can and cannot be tested. The lay description in Ingenix Encoder.Pro identifies no nerves and simply states in part, "…if the test is of sensory response. Each nerve tested can be billed separately." Therefore, reimbursement in the amount of $125.86 (50.35 s 110% = $62.93 x 2) 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 $125.86. 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:

	Marguerite Foster	04/08/2005
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: _____