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.: M4-05-6276-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 42 City of Dallas c/o Harris & Harris P.O. Box 162443 Austin, TX 78716	Date of Injury: Employer's Name: City of Dallas Insurance Carrier's No.: 20043558

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			
12/03/04	12/03/04	95903 (10 Units) & 95904 (10 units)	$1,212.83	$1,212.80

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, "Insurance carrier did not pay per the 2004 Dallas fee guidelines, the adj approve R&N on (12/1/04) for upper and bilateral lower"

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent's Position Summary states in part, "It appears the Requestor seeks additional reimbursement in the amount of $1,212.83 for and EMG/NCV delivered to the Claimant on December 3, 2004. The Respondent reduced the charges per the applicable fee guidelines. The Respondent has reviewed the Requestor's submission of documents and is in the process of reevaluating it audit of this case".

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

- CPT Code 95903 for date of service 12/03/04 denied as "F70 – TWCC Code: F – Fee Guideline MAR Reduction. Exceeds the limitations of the Physical Medicine Ground Rules". The Medicare fee schedule amount plus 125% for this code is $90.29 per nerve. According to Medicare each nerve can be tested separately. The insurance carrier paid $27.09 per nerve, which leaves a balance of $63.20 per nerve. Per Rule 134.202(c)(1) reimbursement in the amount of $632.00 ($63.20 x 10) is recommended.

- CPT Code 95904 for date of service 12/03/04 denied as "F70 – TWCC Code: F – Fee Guideline MAR Reduction. Exceeds the limitations of the Physical Medicine Ground Rules". The Medicare fee schedule amount plus 125% for this code is $72.60 per nerve. According to Medicare each nerve can be tested separately. The insurance carrier paid $14.52 per nerve, which leaves a balance of $58.08 per nerve. Per Rule 134.202(c)(1) reimbursement in the amount of $580.80 ($58.08 x 10) 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 $1,212.80. 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 Typed Name	May 19, 2005 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: _____