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 West 15th St., Ste. 206 Plano, TX 75093	MDR Tracking No.: M4-05-6420-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Co. Box: 19 300 S. State St., One Park Pl. Syracuse, NY 13202	Date of Injury: Employer's Name: Lear Corp. Insurance Carrier's No.: YBUC 88554

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			
12/14/04	12/14/04	92545-76, 92546-76, 92547-76	$395.85	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a Position Summary; however, the requestor's rationale on the table of disputed services states, "The erst of this claim is being denied for maximum number of occurrences for a single date of service or maximum lifetime for the claim has been exceeded. Fee Dispute."

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a Position Summary; however, the respondent's rationale on the table of disputed services states, "Exceeded # of occurences single DOS."

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

- CPT Codes 92545-76, 92546-76, and 92547-76 for date of service 12/14/04. The insurance carrier has made partial payment for the CPT codes in dispute and denied the remainder of the units as "D – Reimbursement for unilateral or bilateral procedures is being withheld as the maximum number of occurrences for a single date of service or maximum lifetime for the claim as has been exceeded." Per Rule 134.202 participants in the Texas Workers Compensation system shall apply the Medicare program reimbursement methodologies for coding, billing, reporting, and reimbursement. Review of Medicare guidelines do not list a maximum number of occurrences for the disputed CPT Codes; however, the health care provider used an incorrect modifier; therefore, additional 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:

Authorized Signature	Marguerite Foster Typed Name	May 25, 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: _____