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.: M4-05-6565-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Employers Insurance Co. of Wausau Box: 28 c/o Liberty Mutual Insurance 2875 Browns Bridge Rd. Gainesville, GA 30504	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			
12/28/04	12/28/04	99213, 95860, 95903, 95904	$1,165.69	$68.24

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, "Denied for no pre-authorization. The adjuster said this did not require pre-authorization this is the first EMG/NCV for the upper extremities. Fee issue."

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, "EMG NCV studies were performed on the upper extremities on 6/12/02, 8/29/02, 8/1/02, 12/28/04 see EOBs. This is the 4th set under this claim number for the upper extremities. TWCC Rules require preauth for repeat diagnostic studies. Preauth was not obtained. MDO was given preauth phone #. See attached EOBs."

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

- CPT Codes 95860, 95903 and 95904 for date of service 12/28/04 were denied as "A – Pre-authorization was required by not requested for this service Per TWCC Rule 134.600". Per Rule 134.600(h)(8) repeat diagnostic testing must be preauthorized. The insurance carrier has submitted convincing evidence that EMG/NCV testing was previously performed on the injured worker and preauthorization was not obtained for the repeat diagnostic testing. Reimbursement is not recommended.

- CPT Code 99213 for date of service 12/28/04 denied as "A – Pre-authorization was required by not requested for this service per TWCC Rule 134.600". Per Rule 134.600 an office visit is not one of the procedures that requires preauthorization. Per Rule 134.202 reimbursement in the amount of $68.24 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 $68.25. 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	May 25, 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: _____