

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. 15 th St., Ste. 206 Plano, TX 75093	MDR Tracking No.: M4-05-8139-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American & Foreign Insurance Co. Box 11 C/o Royal & Sun Alliance P.O. Box 9008 Addison, TX 75001-9008	Date of Injury:
	Employer's Name: Stein Mart Inc.
	Insurance Carrier's No.: 290017845000

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			
08/25/03	08/25/03	99244, 95934-50 & 95934	\$119.22	\$119.22

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position summary; however, their first request for reconsideration states in part, "...I am requesting payment for this CPT 99244 your EOB shows a payment of \$158.35, according to the new guidelines we should have been paid for \$193.15, need additional payment of \$34.80, the EOB also shows CPT 95934-50 was paid according to Fee Guidelines MAR Reduction, our documentation does support the units billed "22 units" for the H/F Waves and it is payable @ \$42.21 for each unit. Documentation of Procedure (DOP) supports the treatment pertaining to the compensable injury and the medical necessity is attached..."

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not submit a position summary.

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

- CPT Code 99244 for date of service 08/25/03 denied as "F – Fee Guidelines MAR Reduction". The Medical Fee Guideline MAR for this code is \$193.15. The insurance carrier paid \$158.35; therefore, per Rule 134.202(b) and (c)(1) additional reimbursement in the amount of \$34.80 is recommended.
- CPT Codes 95934-50 and 95934 for date of service 08/25/03 denied as "F – Fee Guidelines MAR Reduction". The Medical Fee Guideline MAR for these codes is \$42.21 per code. The insurance carrier did not issue payment for these codes. Therefore, per Rule 134.202(b) and (c)(1) reimbursement in the amount of \$84.42 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 \$119.22. 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 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: _____