



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Dr. Pedro Nosnik 4100 West 15 th St. Ste 206 Plano, Texas 75093	MDR Tracking No.: M5-06-1211-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Wausau Underwriters Insurance, Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position paper (Table of Disputed Services) states, "The doctor's documentation supports 'all key components' for these services rendered and therefore, it becomes essential for reimbursement."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
	Medical necessity services were dismissed because of nonpayment of the IRO fee.		

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

Per Rule 133.308 (r)(1)(B), payment of the IRO fee is due prior to the IRO undertaking the review. A Request for Payment of IRO fee was issued on 4-20-06 and the requestor was ordered to remit the IRO fee within ten days. The requestor did not comply; therefore, as stated in the Request, the medical necessity services have been dismissed.

On 4-10-06 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Per the DMEPOS Fee Schedule HCPCS codes A4558 and A4556 on 7-20-05 are bundled codes and will not be paid separately. Request for reconsideration must have the identical codes and charges that are on the original medical bill per 133.304(k)(1)(B).

Regarding HCPCS code A4215 on 7-20-05: A Request for reconsideration must have the identical codes and charges that are on the original medical bill per 133.304(k)(1)(B). Recommend no reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307, 134.202, 133.304 (i) (1-4)
Texas Labor Code 413.011 (d)

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Findings and Decision and Order by:

Donna Auby, Medical Dispute Officer

5-4-06

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.