**Texas Department of Insurance, Division of Workers' Compensation**
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

**Type of Requestor:** (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

| | |
|---|---|
| Requestor's Name and Address:<br>Dr Pedro Nosnik<br>4100 W 15th. Street Suite 206<br>Plano, TX 75073 | MDR Tracking No.: M4-05-6239-01<br>Claim No.:<br>Injured Employee's Name: |
| Respondent's Name and Address:<br>Albertsons Inc.<br>Rep Box # 19 | Date of Injury:<br>Employer's Name: Albertsons Inc<br>Insurance Carrier's No.: YGU28568 C |

## PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states that the carrier did not pay per the fee guideline.

Principle Documentation:

1. Requestor's position statement
2. TWCC-60
3. EOB
4. HCFA's

## PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The respondent states that the requestor has failed to adequately establish entitlement to any further reimbursement.

Principle Documentation: 1. TWCC-60 Response

## PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service | Denial Code | CPT Code(s) or Description | Part V Reference | Additional Amount Due (if any) |
|---|---|---|---|---|
| 11/24/04 | F | 99455 V3 WP | 1 | $00.00 |
| TOTAL DUE | | | | $00.00 |

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled Medical Fee Guideline effective August 1, 2003 set out reimbursement guidelines.

1. CPT Code 99455 V3 WP for date of service 11/24/04 denied with "F" . Per Rule 134.202 (c ) (e)(6)(c )(i)(1) the requestor did not submit a copy of the report to verify the service was rendered as billed. Therefore no additional reimbursement is recommended.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.201
28 Texas Administrative Code Sec. §134.202

**PART VII: DIVISION DECISION AND ORDER**

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**.**

**Ordered by:**

| | | 02/10/06 |
|---|---|---|
| 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.**