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: E. R. McAnalley, M.D., P.A. 4275 Little Road, Suite 202 Arlington, Texas 76016	MDR Tracking No.: M4-05-A294-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Albertsons, Inc. C/O Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Albertsons, Inc. Insurance Carrier's No.: YGU28818

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Insurance Company did not pay correct allowable according to TWCC guidelines. Sent reconsideration showing correct allowable due and insurance company is still denying our claim."

Principle Documentation:
1. Requestor's position statement
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"Charges exceed your contracted/legislated fee arrangement."

Principle Documentation:
1. Respondent's position summary
2. TWCC 60/Table of Disputed Services

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)
03/22/05	C	01400	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 01400 for date of service 03/22/05 was denied "C—Charges exceed your contracted/legislated fee arrangement". The Requestor failed to present pertinent information to dispute or challenge the carrier's position regarding a managed care contract, on this basis reimbursement is not 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 reimbursement.

Ordered by:

		01/27/06
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.