Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed A. Khalifa

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-13-1052-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… in compliance with the office of injured employee's council request which administratively is attached to DWC/TDI, we created a six page narrative report, containing information beyond what was originally required. Toward that end, and as provided by the aforementioned rule we submitted a medical bill for $100, when we could essentially bill for $260.00. However, through irrelevant rationales for denial as they appear on the carrier's E.O.B. and now by misrepresentation of the facts, this carrier attempting to avoid financial responsibility."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the requestor represents it as such, in fact the Office of Injured Employee Counsel is not DWC. A request for clarification from an ombudsman that resulted in a second rating of impairment has no standing with respect to Texas Mutual's obligation to pay a DWC ordered examination, which this was not."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2012	99080	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §404.002 establishes Office of Injured Employee Counsel administrative attachment to Texas Department of Workers' Compensation.
3. 28 Texas Administrative Code §134.120 sets out guidelines for reimbursement for medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC – W1- Workers compensation sate fee schedule adjustment

- CAC – 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- CAC – 193 – Original payment decision is being maintained
- 741 – Reimbursement for designated doctor MMI and/or IR includes responding to need for clarification, explanation or reconsideration.

Issues

1. Is the Office of Injured Employee Counsel part of the Division of Workers' Compensation?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent in their position stated, "Although the requestor represents it as such, in fact the Office of Injured Employee Counsel is not DWC." "Per Texas Labor Code §404.002 (b), "The office is administratively attached to the department but is independent of direction by the commissioner, the commissioner of insurance, and the department…" The respondent's position is correct that the Office of the Injured Employee Counsel is not DWC.
2. Per 28 Texas Administrative Code 134.120 (g) Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or equivalent electronic document format. Clinical or progress notes do not constitute a narrative report.
3. Review of the submitted documentation finds the request was not made by the carrier or the Division. No payment can be recommended..

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 18, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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