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
Zurich American Insurance Co

MFDR Tracking Number
M4-14-1298-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "However, as of today and contrary to DWC rule 133.240(a) we have yet to receive payment."

Amount in Dispute: $43.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: We have requested our third-party repricer to review the bill for the date of service in question to confirm that we have paid the correct recommended allowance. An addendum will be filed when the review is complete, and payment will be issued if any additional allowance is recommended.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2014	99080	$43.00	$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. 28 Texas Administrative Code §129.5 sets out the billing requirements for special reports
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s)
   - 16 –193 – Original payment decision is being maintained

Issues

1. Did the requestor support disputed services are payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 16 - "Claim/service clacks information or has submission billing error(s) which is needed for adjudication. Review of the submitted medical bill contains code 99080. However; Texas Administrative Code §134.120(g) states, "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. However, the documents included in this dispute did not include copy of any such report. The Carrier's denial is supported.
2. The requirements of Division rule 134.120 were not met. No additional 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

Signature	Medical Fee Dispute Resolution Officer	November , 2014 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.