



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

Alief ISD

MFDR Tracking Number

M4-14-1484-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

January 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On October 25, 2013 we submitted the attached medical bill along with supporting documentation related to the date of service October 23, 2013. However, as of today and contrary to DWC rule 133.240(a) we have yet to receive payment."

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...we do not know what is exactly the provider is requesting. The provider is billing a "by report" code with no clarification as to what is being billed... TAC Rule 134.204(j)(1) states: "...The MMI/IR examination shall include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films; (D) the preparation and submission of reports, (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration...)"

Response Submitted by: JI Specialty Services, Inc. P.O. Box 2655, Austin, Texas 78755

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 23, 2013	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. 28 Texas Administrative Code §134.120 sets out guidelines for reimbursement for medical documentation.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 5081 – Per Rule 134.204. The preparation and submission of reports (including narrative report. The need for further clarification, explanation, or reconsideration, is included in the reimbursement of the exam

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied as 97 – “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” Per 28 Texas Administrative Code 134.120 §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films; (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets;” The carrier’s denial is supported.
2. Review of the submitted documentation finds 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	September 30, 2014 Date
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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.