TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA MD

MFDR Tracking Number
M4-18-2892-01

MFDR Date Received
April 16, 2018

Respondent Name
CITY OF HOUSTON

Carrier's Austin Representative
Box Number 29

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or denied this claim in its entirety following our filing of Request for Reconsideration."

Amount in Dispute: $75.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "He seeks payment for a letter of causation that he drafted at the request of the Office of Injured Employee Counsel. Specifically, on 12/07/17 OIEC asked Dr. Khalifa to prepare a letter of causation that would assist [injured employee] in his dispute with the City over the extent of the compensable injury. Dr. Khalifa wrote on 12/18/17 and then billed the City using CPT code 99199."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
December 18, 2017	99199-22	$75.00	$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 the procedures and reimbursement for medical documentation.
3. Texas Labor Code §404.002 establishes the Office of Injured Employee Counsel administrative attachment.
4. Texas Labor Code §404.101 defines the general duties of the Office of Injured Employee Counsel.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
    - 189 – Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service

Issues

Is City of Houston responsible for reimbursement of the disputed service in question?

Findings

Ahmed Khalifa, M.D., is seeking reimbursement for a medical narrative provided on December 18, 2017. Reimbursement of medical narratives is subject to the requirements of 28 Texas Administrative Code §134.120, which states, in relevant part, "(d) If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information."

The documentation submitted to the division includes a letter dated December 7, 2017, requesting the medical narrative in question. The letter was requested by the Office of Injured Employee Counsel (OIEC). Per Texas Labor Code §404.002 (b) administratively attaches the office to the division, but specifies that the office is independent of the division. For this reason, a request from OIEC does not constitute a request from the division per 28 Texas Administrative Code §134.120 (e).

Texas Labor Code §404.101 (b) (2) (C) states that OIEC shall "assist injured employees, through the ombudsman program, in the division's administrative dispute resolution system." The division concludes that the injured employee requested the medical narrative with the assistance of OIEC in accordance with Texas Labor Code §404.101(b) (2) (C). Therefore, per 28 Texas Administrative Code §134.120 (d), City of Houston is not responsible for the reimbursement of the service in question.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	June 7, 2018 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 (BRC) to Appeal a Medical Fee Dispute Decision (MFDD)** (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.