TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed Khalifa, M.D.

Respondent Name
Metropolitan Transit Authority Harris Co.

MFDR Tracking Number
M4-19-2096-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has failed to properly process this Designated Doctor claim. A detailed explanation of benefits was never submitted to our office."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… the provider was reimbursed $800.00 for the MMI and impairment rating portion of the exam, $500.00 for the extent of injury portion of the exam, $100.00 for multiple certifications and $50.00 for the SP modifier … On MMI, the provider was reimbursed $350.00. For the impairment rating portion of the exam, the provider was reimbursed $450.00 … The provider was reimbursed $300.00 for the first musculoskeletal body which was of the upper extremities with range of motion. The provider was reimbursed $150.00 for the non-musculoskeletal body areas. Those covered anxiety, adjustment disorder and depression. Those three constitute one body area."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2018	Designated Doctor Examination	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
    - P12 – Workers' compensation jurisdictional fee schedule adjustment.
    - Comment: "Documentation does not support number of units of billed for CPT 99456-W5. Reimbursement for 2 units is recommended. 1 unit for upper extremities and 1 unit for non-musculoskeletal body area(s)."
    - W3 – Additional reimbursement made on reconsideration.
    - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

Is Ahmed Khalifa, M.D. entitled to additional reimbursement?

Findings

Dr. Khalifa is seeking additional reimbursement of $300.00 for a designated doctor examination performed on September 10, 2018. Flahive, Ogden & Latson argued on behalf of the self-insured that Dr. Khalifa was reimbursed in accordance with the services performed.

The designated doctor is to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[1] Reimbursement is $350.00 for this examination.[2] The submitted documentation supports that Dr. Khalifa performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

Review of the submitted documentation finds that Dr. Khalifa performed impairment rating evaluations of the upper extremities and mental/behavioral conditions. The MAR for the evaluation of the upper extremities, a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of mental and behavioral conditions, a non-musculoskeletal body area, is $150.00.[4] The total MAR for the determination of impairment rating is $450.00.

The submitted documentation indicates that Dr. Khalifa was ordered to address maximum medical improvement, impairment rating, and extent of injury. The narrative report and enclosed forms support that these evaluations were performed, and two additional impairment ratings were provided. Therefore, the correct MAR for this service is $100.00.[5]

The designated doctor is to bill an examination to determine the extent of the compensable injury with CPT code 99456 and modifier "RE." Reimbursement is $500.00 and includes DWC-required reports.[6] The submitted documentation indicates that Dr. Khalifa performed an examination to determine the extent of the injured employee's compensable injury. Therefore, the correct MAR for this examination is $500.00.

Dr. Khalifa referred the injured employee to a specialist to provide a report to aid in determining the impairment rating for mental and behavioral conditions. The use of this report is noted in the narrative. Therefore, the correct MAR for this service is $50.00.[7]

The total maximum allowable reimbursement for the designated doctor examination in question is $1,450.00. Per submitted explanation of benefits dated November 7, 2018, the self-insured reimbursed this amount. No further reimbursement is recommended.

[1] 28 Texas Administrative Codes §§134.250(3)(C) and 134.240(1)(B)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[4] 28 Texas Administrative Code §134.250(4)(D)(v)
[5] 28 Texas Administrative Code §134.250(4)(B)
[6] 28 Texas Administrative Code §134.235
[7] 28 Texas Administrative Code §134.250 (4)(D)(iii)

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	January 18, 2019
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 Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.