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
TASB Risk Management Fund

MFDR Tracking Number
M4-19-4259-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE DD WAS REQUESTED TO ADDRESS ALL OF THE AREAS THAT WERE BILLED FOR. EACH AREA WAS RATED EVEN IF THE GIVEN IMPAIRMENT RATING 0%."

Amount in Dispute: $750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On line 1 of the bill we reimbursed the maximum allowed payment of the MMI (maximum medical improvement) portion of the charges and the IR (impairment rating) for the upper extremity range of motion (ROM) testing. On line 2 of the bill we reimbursed the maximum allowed for the extent of injury testing. This line item was paid in full. On line 3 of the bill we reimbursed the maximum allowed for multiple impairments. This line item was paid in full."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2019	Designated Doctor Examination	$750.00	$450.00

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 examination citing fee guidelines.

Issues

1. What are the services considered in this dispute?
2. Is Dr. Khalifa entitled to additional reimbursement?

Findings

1. Dr. Khalifa is seeking reimbursement for a designated doctor examination that included maximum medical improvement, impairment rating, an extent of injury issue, and multiple assessments of impairment.

   Per explanations of benefits dated March 22, 2019, and April 26, 2019, the insurance carrier reimbursed the determination of extent of injury and the multiple assessments of impairment in full. Therefore, these services will not be considered in this dispute.

   The insurance carrier reduced reimbursement for the determination of maximum medical improvement and impairment rating citing the fee guidelines. These are the services considered in this dispute.

2. The submitted documentation supports that Dr. Khalifa performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   Review of available documentation supports that Dr. Khalifa performed impairment rating evaluations of the left wrist, bilateral carpal tunnel syndrome, diabetes, hypertension, vitamin D deficiency, depression, and anxiety at the request of the insurance carrier. The evaluation of the upper extremities included performance of a full physical examination including range of motion testing.

   Dr. Khalifa failed to include documentation supporting the *AMA Guides*[2] chapter or body area criteria used to determine the impairment from vitamin D deficiency. Because this condition affects multiple body areas, including other areas already listed, this condition will not be considered separately.

   The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of non-musculoskeletal body areas is $150.00 for each body area.[4] The total MAR for the determination of impairment rating is $750.00, as detailed below:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]	[redacted]	$350.00
IR: Left Wrist (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Carpal Tunnel Syndrome			
IR: Diabetes	Endocrine System	Body Systems	$150.00
IR: Hypertension	Cardiovascular System	Body Systems	$150.00
IR: Depression	Mental & Behavioral Disorders	Mental & Behavioral Disorders	$150.00
IR: Anxiety			
Total MMI	[redacted]	[redacted]	**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

   The total MAR for the examinations in question is $1,100.00. The insurance carrier reimbursed $650.00. An additional reimbursement of $450.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $450.00.

[1] 28 Texas Administrative Code §134.250(3)(C)
[2] *AMA Guides to the Evaluation of Permanent Impairment*, Fourth Edition
[3] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[4] 28 Texas Administrative Code §134.250(4)(D)(v)

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $450.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	September 3, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.