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
American Zurich Insurance Company

MFDR Tracking Number
M4-19-4317-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**DR. KHALIFA GAVE AN IMPAIRMENT RATING FOR 6 SEPARATE AREAS FOR THE PATIENT. THE FIRST AREA IS BILLABLE AT $650.00 AND THEN IT IS AN ADDITIONAL $150 FOR EACH EXTRA AREA. SINCE THERE WERE 5 OTHER AREAS, 5*$150=$750. $750 + $650 =$1400 THE BILLABLE AMOUNT."

Amount in Dispute: $450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the provider's narrative report, he provided opinions concerning the impairment rating concerning a brain injury, a right shoulder injury, a left shoulder injury, a right knee injury and a lumbar injury … The provider was entitled to $350 for the MMI portion of the exam, $300 for the first musculoskeletal body area and $150 for the other two musculoskeletal body areas that the provider was entitled to bill for. That would total $350 plus $300 plus $150 plus $150 which totals $950. That is the amount that the provider was reimbursed. The provider is not entitled to any additional reimbursement, regardless of the number of musculoskeletal body areas because the provider may bill for a maximum of three body areas."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2018	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	$450.00	$300.00

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:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is Dr. Khalifa entitled to additional reimbursement for the services in question?

Findings

Dr. Khalifa is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating performed on September 6, 2018. The insurance carrier reduced reimbursement citing the fee schedule.

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.[1]

The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of subsequent musculoskeletal body area is $150.00.[3] The MAR for the evaluation of non-musculoskeletal body area is $150.00.[4]

Documentation submitted to the DWC supports that Dr. Khalifa performed evaluations of impairment for the lumbar spine, left shoulder, right shoulder, right knee, hearing loss, and a brain injury. While left 1-9 rib fractures were considered, no impairment was assigned to these injuries.

Per the doctor's narrative, the impairment rating for the lumbar spine was based on Table 72, page 3/110. The left and right shoulder impairment ratings were based on Table 3, page 3/20. The impairment rating for the right knee was based on Table 41, page 3/78. The impairment rating for hearing loss was established using Table 1, page 9/226; Table 2, page 9/226; and Table 3, page 9/228. The impairment rating for the brain injury was based on Table 1, page 4/141; Table 2, page 4/142; Table 3, page 4/142; and Section 4.1, page 4/140. The DWC concludes that Dr. Khalifa is entitled to reimbursement as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Left Shoulder (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Right Shoulder (ROM)			
IR: Lumbar Spine		Spine and Pelvis	$150.00
IR: Right Knee (ROM)		Lower Extremities	$150.00
IR: Hearing Loss	Ear, Nose, Throat, and Related Structures	Body Structures	$150.00
IR: Brain Injury	Nervous System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

The total allowable reimbursement for the services in question is $1,250.00. The insurance carrier reimbursed $950.00. An additional reimbursement of $300.00 is recommended.

[1] 28 Texas Administrative Code §134.250(3)(C)
[2] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[3] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-b-)
[4] 28 Texas Administrative Code §134.250(4)(D)(v)

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 $300.00.

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 $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 14, 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.