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
KHALIFA, AHMED A H

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-21-0547-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
November 30, 2020

REQUESTOR'S POSITION SUMMARY

"The insurance carrier is in violation of Rule 133.204, 133.210, 133.230 and Texas Labor Code 408.0041 as the carrier received the attached Designated Doctor claim and attachments timely. See proof of timely submission. The carrier has not provided payment on this claim or has denied this claim inappropriately. The aforementioned rule indicates the carrier must reimburse the Designated Doctor claim within 45 calendar days from the date of receipt. The carrier is also responsible for their bill review agent and cannot use this as a reason for non payment or non response to a claim."

Amount in Dispute: $1,450.00

RESPONDENT'S POSITION SUMMARY

"The Carrier has reviewed the documentation and determined the Provider is entitled to reimbursement for the disputed services. Reimbursement is being issued in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2020	Designated Doctor Examination (99456-W5-WP)	$1,400.00	$150.00
February 21, 2020	Specialist Report Incorporation (99456-SP)	$50.00	$0.00
	Total	$1,450.00	$150.00

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 (DWC).

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.

Issues

Is Ahmed Khalifa, M.D. entitled to additional reimbursement for the examination in question?

Findings

Dr. Khalifa is seeking additional reimbursement for a designated doctor examination performed on February 21, 2020. Per explanation of benefits dated December 11, 2020, Travelers Indemnity Company paid $1,150.00.

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

Review of the submitted documentation finds that Dr. Khalifa performed impairment rating evaluations of the right shoulder, bilateral knees, and right ankle with range of motion; aortic arch with pseudoaneurysm; retroperitoneal hematoma; traumatic brain injury; left pleural effusion versus hemothorax; and rib fracture. 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 areas is $150.00 each.[3] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[4] The total MAR for the determination of impairment rating is $1,050.00.

The submitted documentation shows that the requestor referred the injured employee to a specialist to provide a report to aid in determining the impairment rating for the injured employee's head injuries and psychological issues. The use of this report is noted in the narrative. Therefore, the correct MAR for this service is $50.00.[5]

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Right Shoulder (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Bilateral Knees (ROM)		Lower Extremities	$150.00
IR: Right Ankle (ROM)			
IR: Aortic Arch w/ Pseudoaneurism	Cardiovascular System	Body Systems	$150.00
IR: Retroperitoneal Hematoma			
IR: Traumatic Brain Injury	Nervous System	Body Systems	$150.00
IR: Left Pleural Effusion versus Hemothorax	Respiratory System	Body Systems	$150.00
IR Rib Fracture			
Total MMI	[redacted]		**$350.00**
Total IR			**$900.00**
Specialist Report			**$50.00**
Total Exam			**$1,300.00**

The total allowable reimbursement is $1,450.00. The insurance carrier paid $1,150.00. An additional reimbursement of $150.00 is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 $150.00.

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[4] 28 TAC §134.250(4)(D)(v)
[5] 28 TAC §134.250 (4)(D)(iii)

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 $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		February 26, 2021
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.