TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Ahmed Khalifa

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-22-0413-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 1, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 8, 2021	99456 W5 NM	$350.00	$0.00
February 8, 2021	99456 W6 RE	$500.00	$0.00
February 8, 2021	99456 W5 MI	$50.00	$0.00
	Total	$900.00	$0.00

Requestor's Position

The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety…

Amount in Dispute: $900.00

Respondent's Position

Our bill audit company has determined additional monies are owed in the amount of $900.00 plus interest owed $4.93. Attached is a copy of the EOB and payment summary for your records.

Response submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment
- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance.

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking reimbursement of the following designated doctor services and amount.

    - 99456 W5 NM
    - 99456 W6 RE
    - 99456 W5 MI

    DWC Rule 28 TAC §134.250 (2)(A) to bill CPT code 99456 and modifier "NM" when the designated doctor determines that maximum medical improvement has not been reached.

    The submitted documentation supports that Dr. Ahmed Khalifa performed an evaluation of maximum medical improvement as ordered by DWC. DWC Rule 28 TAC §134.250 (3)(C) requires that the maximum allowable reimbursement for this examination is $350.00.

    DWC Rule 28 TAC §134.240 (1)(C) requires extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W6". DWC Rule 28 TAC §134.235 states when conducting a division or

insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. The submitted documentation supports that Dr. Ahmed Khalifa performed an evaluation of extent of injury as ordered by DWC.

DWC Rule 28 TAC §134.250 (2)(C) states if the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed. Review of the submitted documentation found MMI not reached. No additional payment is recommended.

2. The total MAR (maximum allowed reimbursement) is $850.00. The insurance carrier submitted documentation to support a payment was made December 20, 2021, in the amount of $900.00 via check number 0176008786.

   No additional payment is recommended.

Conclusion

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

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 11, 2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field

office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.