



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

Great Midwest Insurance Company

MFDR Tracking Number

M4-18-1653-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 11, 2017, Designated Doctor Examination, \$150.00, \$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.

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:
- 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.
- 6666 - The billing of the procedure code has exceeded the National Correct Coding Initiative Medical Unlikely Edit value.

Issues

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

Findings

Dr. Khalifa is seeking an additional \$150.00 for a designated doctor examination to determine maximum medical improvement and impairment rating for three body areas.

Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." 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.

28 Texas Administrative Code §134.250(4) states:

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.
- (D) ...
 - (i) Non-musculoskeletal body areas are defined as follows:
 - (I) body systems;
 - (II) body structures (including skin); and,
 - (III) mental and behavioral disorders.
 - (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...
 - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the requestor performed impairment rating evaluations, including full physical evaluation with range of motion of the neck/head, upper extremities, and skin. The MAR for this examination is \$600.00.

The total MAR for the disputed examination is \$950.00. The insurance carrier reimbursed \$800.00. An additional reimbursement of \$150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division 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

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

August 2, 2018
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.