TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MIRRO, NICHOLAS

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-20-2257-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 13, 2020

REQUESTOR'S POSITION SUMMARY

"We request 100% reimbursement for the services billed. The patient was treated for MMI evaluation and IR both and was properly billed with modifier 'WP' indicating the reimbursement is 100 percent of the total MAR …

350 MMI determination
300 1st musculoskeletal body area (Right upper extremity)
150 1st additional body area (Cervical spine)
$800"

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

"CRF acknowledges that this provision provides for payment of $300 associated with a full physical evaluation with range of motion testing for the first musculoskeletal area. Additionally, payment of $150 is allowed for each additional musculoskeletal area. However, in this claim, Dr. Mirro's office never billed for a spinal component as part of the impairment evaluation … Accordingly, Dr. Mirro's office is owed $650, which CRF has now paid in full."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$300.00	$0.00

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.
3. The insurance carrier reduced payment for the disputed services citing fee guidelines.

Issues

Is Nicholas Mirro, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Mirro is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

The examining doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456." Reimbursement is $350.00 for this examination.[1] The submitted documentation supports that Dr. Mirro performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

The examining doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456. The number of body areas are indicated in the units column of the billing form.[2] The submitted documentation supports that Dr. Mirro provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

The evidence submitted to the DWC shows that Dr. Mirro billed for the examination with CPT code 99456-WP with one unit.

The DWC finds that the total allowable reimbursement for the examination in question is $650.00. Per explanations of benefits dated July 30, 2019, and May 28, 2020, the insurance carrier paid this amount in full. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 29, 2020 Date

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §§134.250(4)(A)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.