



**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 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

Juan Capello, MD

**Respondent Name**

City of San Antonio

**MFDR Tracking Number**

M4-15-0307-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

September 19, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The following bill was audited and paid incorrectly...Rule 134.204, Subsection (J), Subsection (4), Subparagraph (C), (ii), (II). This rule states if a full physical evaluation, with range of motion is performed, reimbursement for the first musculoskeletal body area is \$300.00 ...."

**Amount in Dispute:** \$150.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The issue is in regards to whether a reimbursement amount is owed for range of motion measurements when the impairment rating billed under procedure code 99456W5WP was determined by the DRE method.

The enclosed medical records do not document a percentage of impairment based on the range of motion measurements. Per Juan Capello MD, "...it is determined the examinee's injury is best rated under DRE (Diagnosis Related Estimate) Category II, for 5% whole person impairment of the lumbar spine."

According to the Texas Workers' Compensation Medical Fee Guideline 28 TAC §134.204 (j)(C)(ii)(1), the MAR for musculoskeletal body areas shall be \$150.00 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4<sup>th</sup> edition is used.

The prior reimbursement of \$350.00 for maximum medical improvement and \$150.00 for impairment rating was in accordance with the Medical Fee Guideline and no additional allowance is due."

**Response Submitted by:** Argus Services Corporation, 811 S. Central Expwy, Ste. 440, Richardson, TX 75080

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2014	Impairment Rating of a Musculoskeletal Body Area	\$150.00	\$150.00

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.204 sets out fee guidelines for Workers' Compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1A – Workers Compensation State Fee Schedule Adjustment \*Reimbursement per Rule 134.203/204. Prior to March 1, 2008, Rule 134.202\*
  - W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule.

## Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the total allowable amount for the impairment rating?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation of the spine, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states that "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**" [emphasis added].

The Division notes that the document titled Medical Dispute Resolution Newsletter, No: 4, March 2005, submitted by the requestor in support of its request is not applicable to the services in dispute. This article titled Billing and Reimbursement for an Impairment Rating: ROM vs. DRE discusses former §134.202, which is not applicable to the disputed service. The applicable rule is, as stated above, 28 Texas Administrative Code §134.204 adopted to be effective March 1, 2008, 33 TexReg 36.

2. According to the explanation of benefits, the total of \$150.00 was reimbursed by the carrier for the IR of the spine. The carrier alleges that this amount was appropriately calculated based upon §134.204(j)(4)(C)(ii)(I). The requestor disagrees. In its position, the requestor argues that the carrier should have allowed a total of \$300.00 for the impairment rating of the spine because it asked for reimbursement based upon §134.204(j)(4)(C)(ii)(II)(**-a-**)[emphasis added]. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(II)(**-a-**), the health care provider, in this case, was required to perform a full physical evaluation with range of motion of the spine. Review of the submitted documentation finds that a full physical evaluation and range of motion were performed on the spine. The Division concludes that the impairment rating of the spine is allowed at \$300.00 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(**-a-**).
3. The division concludes that the total allowable for the impairment rating of the spine is \$300.00. The respondent issued payment in the amount of \$150.00 for the IR of the spine. Based upon the documentation submitted, additional reimbursement in the amount of \$150.00 is recommended.

## Conclusion

This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though all the evidence was not discussed, it was considered. 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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$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

January 7, 2015  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.**