



**Texas Department of Insurance, Division of Workers' Compensation**  
 7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION**  
**Retrospective Medical Necessity and Fee Dispute**

**PART I: GENERAL INFORMATION**

**Type of Requestor:** (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:  
 Coastal Spine Medical Center  
 5327 S. McColl Road  
 Edinburg, Texas 78539

MDR Tracking No.: M5-06-0174-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:  
 Texas Mutual Insurance Company  
 Box 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

DOCUMENTATION SUBMITTED: DWC-60 dispute package

POSITION SUMMARY: Per the table of disputed services "the care rendered to the patient has met criteria set by Texas Labor code section 408.21 complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute".

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: No position summary submitted by Respondent

**PART IV: SUMMARY OF DISPUTE AND FINDINGS**

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-20-04 and 09-21-04	99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$88.32
10-18-04 and 10-19-04	97110	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$335.36
09-20-04 to 10-19-04	97140, 97113, 97112, 97124 and 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

**PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor **did not prevail** on the **majority** of the disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 10-10-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code G0283 date of service 09-20-04 was denied by the carrier with denial codes "F/105" (Fee guideline MAR reduction/This provider has been reimbursed the additional HPSA amount). The carrier has made a payment of \$14.75. Per the 2002 Medical Fee Guideline no additional reimbursement is recommended.

CPT code 99212 dates of service 09-28-04 and 09-30-04 denied with denial code "864" (E/M services may be reported only if the patient's condition requires a significant separately identifiable E/M service). Documentation submitted by the Requestor supports the services in dispute per Rule 133.307(g)(3)(A-F). Reimbursement is recommended in the amount of **\$88.32 (\$44.16 X 2 DOS)**.

CPT code 97110 dates of service 10-04-04, 10-05-04, 10-06-04, 10-12-04 and 10-15-04 denied with denial codes "F/435" (Fee Guideline MAR reduction/the value of the procedure is included in the value of the comprehensive procedure). Per the 2002 Medical Fee Guideline code 97110 is considered to be a component procedure of code 97113 billed on the dates of service in dispute. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor did not bill using a modifier. No reimbursement is recommended.

CPT code 99212 dates of service 10-05-04, 10-06-04, 10-18-04 and 10-19-04 denied with denial codes "F/105" (Fee guideline MAR reduction/This provider has been reimbursed the additional HPSA amount). The carrier has made a payment of \$194.32. Per the 2002 Medical Fee Guideline no additional reimbursement is recommended.

CPT code 99212 date of service 10-12-04 denied with denial code "F" (Fee guideline MAR reduction). The carrier has made a payment of \$44.16. Per the 2002 Medical Fee Guideline no additional reimbursement is recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1)

**PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$512.00. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

\_\_\_\_\_  
Authorized Signature

12-27-05

\_\_\_\_\_  
Date of Order

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

### REVISION II - 12/22/05

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0174-01
Name of Patient:	_____
Name of URA/Payer:	Coastal Spine Medical Center
Name of Provider: (ER, Hospital, or Other Facility)	Coastal Spine Medical Center
Name of Physician: (Treating or Requesting)	Pete E. Garcia, MD

October 31, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating

physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Division of Workers' Compensation

#### CLINICAL HISTORY

Records submitted for review included:

- Records from Coastal Spine Medical Center correspondence, Daily Progress Notes; review of medical history and physical exam dated 12/17/04; Spectrum Imaging report dated 9/14/04; and
- Texas Mutual Insurance carriers position, Northwest Regional Hospital records, Coastal Spine Medical Center Narrative Reports (8/25/04, 9/8/04, 9/22/04, 10/8/04, 10/27/04).

The request for IRO document is reviewed. The requestor noted that there was an injury to the anterior talofibular ligament and thus determined this to be a "Neurologic injury". There is a letter of explanation noted from Mara Hernandez of Coastal Spine Medical Center alleging that rehabilitation of the sprained ankle required that the primary treating physician kept close supervision to complete a problem focused history, problem focused examination and straightforward medical decision. Ms. Hernandez also confused a torn ligament with a neurologic injury. Multiple HCFA's from Coastal Spine were noted. Beginning September 201, 2004 daily chiropractic and rehabilitation notes were reviewed. Strength was noted as "5/5" with a decreasing effusion. The diagnosis listed was "ankle sprain". A Designated Doctor evaluation of December 14, 2004 noted maximum medical improvement with a 0% whole person impairment rating. The Designated Doctor noted the date of injury, the assessment of a sprained ankle, several weeks of passive therapy and then eight weeks of work hardening. The MRI noted the ATF to be torn, but the remainder of the ligaments to be intact. Plain films were consistent with a soft tissue injury. The initial examination of Dr. Garcia noted a normal neck and back examination, normal motor function in other the upper extremity and lower extremity and a normal sensory examination. Dr. Garcia ordered daily passive physical therapy for the

sprained ankle. Dr. Garcia also kept the claimant off work through the end of October and suggested a work hardening program (although there are no psychiatric maladies noted).

#### REQUESTED SERVICE(S)

Therapeutic Exercises (97110); Office visits (99212); Neuromuscular Re-education (97112); Manual Therapy (97140); Aquatic Therapy (9713); Massage Therapy (97124) and Ultrasound (97035) for dates of service 9/20/04 through 10/19/04.

#### DECISION

Approve office visits and therapeutic exercise.

Deny all other requested services.

#### RATIONALE/BASIS FOR DECISION

None of the passive modalities were warranted. There is an indication for up to five sessions of therapeutic exercise, office visits and none of the remainder. As noted in Wheelless Text of Orthopedics; this ligament is the weakest of the lateral ligaments; it prevents anterior subluxation of talus when ankle is in plantar flexion; the orientation of ant talofibular ligament depends on position of ankle Joint. In plantar flexion, it is parallel to long axis of foot, whereas in dorsiflexion, it is aligned with the tibial and fibular shafts. A strain in ATFL is minimum in dorsiflexion & neutral, & it increased as ankle is moved progressively thru plantar flexion. Also writing in Wheelless; Balduini FC. Vegso JJ. Torg JS. Torg E. University of Pennsylvania, Sports Medicine Center, Philadelphia. Sports Med.4(5):364-80, 1987 Sep-Oct. Note ankle sprains are a common occurrence, with the majority involving the lateral ligament complex. Within this complex, the anterior talofibular ligament is injured most frequently, usually while the foot is in the plantar flexed position. Ankle injuries can be diagnosed through physical exam, including the anterior drawer test and/or a stress exam, or through roentgenographic evaluation. The purpose of the stress roentgenogram is to measure the degree of talar tilt. However, it does not always yield consistent, reliable results. This inconsistency has led to the use of arthrography. There is debate over its use as well; however, Ankle sprains can be classified into three groups, according to functional loss. Treatment for first and second degree sprains is usually non-operative. The best approach to Grade III sprains is debatable. The issues in the treatment of Grade III

sprains are first, whether treatment should be operative or non-operative, and second, whether non-operative treatment should emphasize immobilization or mobilization. Brostrom's work is cited as noteworthy. He recommended adhesive strapping followed by mobilization as the treatment of choice, and reserves surgery for cases of chronic instability. Results demonstrated that strapping yielded shorter disability periods, while surgery produced less instability. The prevention of functional instability is a major concern in the treatment of ankle injuries. There is no clear cut treatment plan, but after a brief period of immobilization, then active measures to regain range of motion are indicated. Loss of motion is designated as a primary cause of chronic pain and re-injury, and exercises intended to restore range of motion are provided. Exercises aimed at restoring strength and proprioception is also presented. This allows for return to activity and serves to prevent re-injury.

***As noted in the Official Disability Guideline:*** the treatment is very straightforward A trilateral splint should be applied initially for two to three weeks. The patient will need crutches and should avoid weight bearing. Swelling is controlled with constant elevation above the heart. Ice and elevation for 24-48 hours is appropriate. Weight-bearing is progressed to 50% with crutches until six weeks post injury when full weight-bearing is allowed and crutches are discontinued. Analgesics and/or non-steroidal anti-inflammatory drugs for up to two weeks are appropriate. Pain is usually due to swelling, and is best controlled with elevation of the ankle and foot. The patient should be rechecked seven to ten days after the date of injury, seven to ten days after beginning partial weight-bearing, and after progressing to full weight-bearing. Physical therapy (one to five visits) to teach patient range-of-motion and muscle-strengthening exercises may be needed after immobilization. Prescribe level of activity at work and job modifications at each visit. Early mobilization, functional treatment and partial weight bearing as tolerated appear to be a favorable treatment strategy for acute ankle sprains when compared with immobilization. (Kerkhoffs-Cochrane, 2002) (Shrier, 1995) Functional treatment comprises a broad spectrum of treatment strategies. The use of an elastic bandage has fewer complications than taping but appears to be associated with a slower return to work, and more reported instability than a semi-rigid ankle support. Lace-up ankle support appears effective in reducing swelling in the short-term compared with semi-rigid ankle support, elastic bandage and tape. (Kerkhoffs, 2002)

Massage is not recommended. There is little information available from trials to support the use of many physical medicine interventions for treating disorders of the ankle and foot. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. See also Manipulation. (Crawford, 2002) (Van der Windt, 2001)

Physical therapy should be active and exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be advised to do early passive range-of-motion exercises at home by a physical therapist. See also specific physical therapy modalities by name. (Colorado, 2001) (Aldridge, 2004)

There was no neurologic injury so no neuromuscular re-education is warranted or indicated.

A review of the literature makes no reference to aquatic therapy being a first line intervention for a sprained ankle. That would have to be considered excessive. Similarly for massage and ultrasound, there is no competent, objective and independently confirmable medical evidence to support the treatment plan provided. This appears to be using any device or apparatus available for an injury that essentially resolves on its own with minimal intervention.

#### Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

## YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell