



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0477-01
Beeville Medical Assoc. PO Box 33306 San Antonio, TX 78265-3306	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
State Office of Risk Management, Box 45	Employer's Name:
	Insurance Carrier's No.:

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

Documents include the DWC 60 package. Position summary states, "Documentation to support length of treatment was attached to claims at time of submission and appeal."

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

Documents include the DWC 60 response. Position summary states, "The office will maintain its denial for all dates of service, CPT code 97530 and 9112, as the provider was reimbursed 45 minutes in accordance with Medicare PM & R guidelines for P.T. in an office or home setting. No medical documentation received to support the necessity of unusual length of time for physical therapy."

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
7-5-05 – 7-22-05	CPT codes 97530 and 97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### 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 disputed medical necessity issues.

Based on review of the disputed issues within the request, the 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.

CPT code A4556 on 7-6-05 was denied by the carrier as “R-38 – Included in another billed procedure.” On 1-18-06 the requestor submitted the medical notes for this date of service. Per the 2002 MFG this is a bundled service. Recommend no reimbursement.

CPT code 97002-25-59 on 7-22-05 was denied by the carrier as “B-15-Procedure/Service is not paid separately” and as “R-79-CC: Standards of Medial/Surgical Practice”. On 1-18-06 the requestor submitted the medical notes for this date of service. Per the 2002 MFG this service is a component procedure of CPT codes 97110, 97112, and G0283 which were billed on this date of service. A modifier was used in order to differentiate between the services, however, the medical notes do not support the modifier which was billed. Recommend no reimbursement.

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

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

**PART VII: DIVISION DECISION**

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 not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Donna Auby

1-18-06

Authorized Signature

Typed Name

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.**

## NOTICE OF INDEPENDENT REVIEW DECISION

January 11, 2006

Program Administrator  
Medical Review Division  
Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Claim #:  
Injured Worker: \_\_\_\_\_  
MDR Tracking #: M5-06-0477-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Orthopedic Surgery which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1969. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained a work related injury on \_\_\_ when she slipped on a damp floor and injured her left knee. An MRI of the left knee indicated a possible intrasubstance tear. An MRI of the left ankle indicated a strain and/or tear of the anterior and posterior talobibular ligaments. In addition there was a partial tear of the flexor hallucis longus muscle and tendon at the level of the ankle joint.

### Requested Service(s)

Therapeutic activities (97530) and neuromuscular re-education (97112) from 07/05/05 to 07/22/2005

### **Decision**

It is determined that the therapeutic activities (97530) and neuromuscular re-education (97112) from 07/05/05 to 07/22/2005 were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

Code 97530 is therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance). Code 97112 is neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.

Neither of these codes is applicable to the soft tissue injury trauma suffered by this patient. Therefore, neither 97530 nor 97112 were appropriate therapies to treat this patient's condition

This decision by the IRO is deemed to be a DWC decision and order.

### **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.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

Attachment