



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: Summit Rehabilitation Centers 2420 E Randol Mill Road Arlington, Texas 76011	MDR Tracking No.: M5-06-0573-01 (previous MDR#) M5-06-1104-01 (new MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Rep 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: No position summary submitted

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

DOCUMENTATION SUBMITTED: Response to DWC-60  
POSITION SUMMARY: "Texas Mutual requests that the request for dispute resolution filed by SUMMIT REHABILITATION CENTERS INC, be conducted under the provisions of the APA set out above".

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
01-13-05 to 06-07-05	97140, 96004, 99213, 97110 and G0283	<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 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 12-20-05, 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 95832 (1 unit) dates of service 01-13-05, 01-20-05, 01-26-05, 02-04-05, 03-22-05 and 04-13-05 either denied with denial codes "G/435/97" (unbundling/the value of the procedure is included in the value of the comprehensive procedure or payment is included in the allowance for another service/procedure or review revealed that neither party submitted a copy of an EOB per Rules 133.307(e)(2)(B) and 133.307(e)(3)(B). Per the 2002 Medical Fee Guideline CPT code 95832 is considered to be a component procedure of code 99213 billed on the dates of service in dispute. There are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately. No reimbursement recommended.

CPT code 97110 (1 unit) date of service 01-14-05 was denied with denial code "F/790" (charge was reduced in accordance to the Texas Medical Fee Guideline). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set form in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Division requirements for proper documentation. The MRD declines to order payment because per Rule 133.307(g)(3)(A-F) the Requestor did not submit documentation for review. Reimbursement not recommended.

CPT code 99080-73 date of service 04-12-05 denied with denial code "248" (TWCC-73 not properly completed or submitted in excess of the filing requirements; reimbursement denied per Rule 129.5. The Requestor per Rule 133.307(g)(3)(A-F) did not submit documentation for review. No reimbursement recommended.

CPT code 96004 date of service 04-13-05 denied with denial codes "97/217" (payment is included in the allowance for another service/procedure). Per the 2002 Medical Fee Guideline code 96004 is not global to other services billed on date of service 04-13-05. Reimbursement is recommended per Rule 134.202 in the amount of **\$155.25**.

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

28 Texas Administrative Code Sec. 133.308, 134.202, 133.307(g)(3)A-F, 133.307(e)(2)(3)(B)

**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 \$155.25. 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:

05-03-06

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

\_\_\_\_\_  
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.**

**Envoy Medical Systems, LP**  
**1726 Cricket Hollow**  
**Austin, Texas 78758**

Phone 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

**NOTICE OF INDEPENDENT REVIEW DECISION**

April 11, 2006

**Re: IRO Case # M5-06-1104 -01** \_\_\_\_

Texas Department of Insurance, Division of Workers' Compensation:

Envoy Medical Systems, LP (Envoy) has been certified as an Independent Review Organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Division of Workers' Compensation cases. Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that cases be assigned to certified IROs, this case was assigned to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for the Division of Workers' Compensation Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and the injured employee, the injured employee's employer, the insurance carrier, the utilization review agent, any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. DDE and IR 5/11/05, Dr. Shade
4. Operative reports 12/28/04, 11/8/04, Consult note 11/8/04 Dr. Dulin
5. Admission H&P 1/24/05, follow up notes 1/31/05 – 6/6/05, Dr. Ippolito
6. Medical notes 1/20/05, 5/26/05, Dr. Small
7. Chiropractic and therapy notes 1/26/05 – 6/7/05, Dr. Subia
8. Grip strength testing reports 1/13/05, 4/13/05

History

The patient sustained a crush injury to the right thumb in \_\_\_\_\_. He immediately underwent open reduction and internal fixation, repair of the flexor pollicis longus, repair of the radial digital

nerve, nail bed repair, and open flap closure of the open wound. The patient then underwent pin removal x 2 of the right thumb distal phalanx, and manipulation of the right thumb under anesthesia on 12/28/04. Further surgical reconstruction of the patient's thumb was performed in February 2005. The patient then underwent three months of physical and occupational therapy.

Requested Service(s)

Office visits, therapeutic exercises, manual therapy technique, electrical stimulation, physician review/interpretation of comprehensive computer based motion analysis etc. with written report 1/13/05 – 6/7/05.

Decision

I agree with the carrier's decision to deny the requested physical therapy services, office visits and testing services.

Rationale

The patient underwent physical therapy during the dates in dispute. Physical therapy services were reimbursed during this time period. The services that were not reimbursed and that are disputed are excessive and exceed current treatment guidelines for medical necessity. Current medicare guidelines limit physical therapy sessions to no more than three times per week for 45 minutes per session on non-consecutive days.

This medical necessity decision by an Independent Review Organization is deemed to be a Workers' Compensation Division decision and order.

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 a 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 the 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 must be received by the Division of Workers' Compensation, chief Clerk of Proceedings, within then (10) days of your receipt of this decision.

Sincerely,

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Daniel Y. Chin, for GP