



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: Dorinda Rodriguez, OTR, CHT 1104-B W Sam Houston Pharr, Texas 78577	MDR Tracking No.: M5-06-1122-01
	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  
POSITION SUMMARY: Per the table of disputed services "medical necessity".

#### 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 SOUTH TEXAS HAND THERAPY LTD, 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)
02-21-05 to 05-12-05	97140-GO (2 units @ \$63.58 X 23 DOS- \$123.83 payment)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,338.51
	97032-GO (1 unit @ \$19.00 X 1 DOS)		\$19.00
	97035-GO (1 unit @ \$14.63 X 5 DOS)		\$73.15
	97535-GO (1 unit @ \$35.50 X 1 DOS)		\$35.50
	97110-GO (4 units @ \$134.24 X 3 DOS- \$281.88 payment)		\$120.84
	97110-GO (2 units @ \$67.12 X 10 DOS- \$184.56 payment)		\$486.64
	97110-GO (3 units @ \$100.68 X 1 DOS- \$33.56 payment)		\$67.12
	97530-59-GO (2 units @ \$70.30 X 3 DOS- \$63.43 payment)		\$147.47
	97112 (1 unit @ \$35.21 X 1 DOS)		\$35.21
	<b>TOTAL</b>		<b>\$2,323.44</b>

#### 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 **prevailed** 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 05-05-06, 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 97004-GO date of service 04-19-05 listed on the table of disputed services was indicated to have been paid by the carrier. Payment was verified via telephone with the Requestor's office on 05-03-06. This code will not be part of the review.

CPT code 97022-GO (1 unit) date of service 03-14-05 denied with denial code "97" (global). Per the 2002 Medical Fee Guideline code 97022-GO was not global to other services billed on date of service 03-14-05. Reimbursement in the amount of **\$17.28** is recommended per Rule 134.202.

CPT code 97530-59-GO (2 units) date of service 04-28-05 denied with denial code "97" (global). Per the 2002 Medical Fee Guideline code 97530-59-Go is considered to be a mutually exclusive procedure of CPT code 97140 billed on the same date of service. 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 appropriately billed modifier 59. Reimbursement is recommended in the amount of **\$70.30** per Rule 134.202.

CPT code 97530-59-GO (2 units) dates of service 05-10-05 and 05-12-05 denied with denial code "24" (payment for charges adjusted, charges are covered under a capitation agreement/managed care plan). The carrier did not submit a copy of the capitation agreement. Reimbursement is recommended in the amount of **\$140.60** per Rule 134.202.

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

28 Texas Administrative Code Sec. 133.308 and 134.202

**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 \$2,551.62. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$650.00). 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:

05-16-06

\_\_\_\_\_  
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 15, 2006

Re: IRO Case # M5-06-1122 -01 \_\_\_ amended 11/24/06

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 Orthopedic Surgery and is a Fellowship-trained hand surgeon, 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. Letters 1/9/06, 6/27/05, D. Rodriguez
4. TWCC 69 5/6/05
5. TWCC work status reports
6. Medical records 2/05 - 5/05, Dr. Goldsmith
7. Notes, South Texas Hand Therapy
8. Occupational therapy treatment and exercise log, and daily treatment record, South Texas Hand Therapy
9. Exercise sheets
10. Consultation and operative reports 2/4/05, Dr. Corley

### History

The patient suffered a complex open injury to the left index finger \_\_\_\_. There was a significant delay in his care, and he was transferred about 300 miles to San Antonio, where the wound was debrided and stabilized with a single pin. Subsequently the patient underwent a ray amputation on 2/7/05. His post-operative hand therapy was started in February 2005, some of which was deemed to be medically unnecessary by the carrier.

### Requested Service(s)

Therapeutic exercises, manual therapy technique, electrical stimulation, ultrasound, therapeutic activities, neuromuscular re-education, self care home training 2/21/05 - 5/12/05

### Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The patient suffered a complex open injury to the hand that required extensive physical therapy in excess of 45 minutes per session. Based on the records provided, all of the physical therapy and modalities provided to the patient were medically appropriate and necessary, given the complexity and severity of the patient's injury. The therapy was professionally administered as ordered by the patient's physicians. Self care home training is medically appropriate.

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