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: South Texas Hand Therapy 1104-B W. Sam Houston Pharr, Texas 78577	MDR Tracking No.: M5-06-1856-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Rep Box # 54	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Medical Necessity."
Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The position statement submitted by Texas Mutual does not address the disputed services.
Principle Documentation:

1. Response to DWC 60.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-12-05 to 10-05-05	97035, 97140, 97535 and 97039	☐ Yes ☒ No	$0.00
	TOTAL DUE		$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, Medical Dispute Resolution has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained fee issues that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 08-09-06, Medical Dispute Resolution 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.

HCPCS code A6422 billed for date of service 08-02-05 was denied by the Respondent with denial codes "96" (non-covered charge), "W1" (Workers Compensation State Fee Schedule Adjustment), "290" (this code is invalid, not covered code or has been deleted from the Texas Fee Schedule or Medicare) and "790" (This charge was reduced in accordance to the Texas Medical Fee Guideline). Per the 2005 DMEPOS Fee Schedule this is not a valid HCPCS code. No reimbursement is recommended.

CPT code 99070 billed for date of service 08-02-05 was denied by the Respondent with denial codes "97" (payment is included in the allowance for another service/procedure), "W1" (Workers Compensation State Fee Schedule Adjustment), "284" (no allowance was recommended as this procedure as a Medicare status of 'B' (bundled)) and "790" (This charge was reduced in accordance to the Texas Medical Fee Guideline). Per Rule 134.202 CPT code 99070 is a bundled code, therefore, no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS AND 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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

		10-02-06
Authorized Signature	Typed Name	Date of Findings and Decision

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.

Date:	**09/06/2006** **Corrected Copy 09/07/2006** **Corrected CPT Code 09/27/2006**

	Corrected Copy 09/28/2006
Injured Employee:	
MDR #:	**M5-06-1856-01**
DWC #:	
MCMC Certification #:	**TDI IRO-5294**

REQUESTED SERVICES:
Please review the item(s) in dispute: Ultrasound (97035), manual therapy technique (97140), self-care management training (97535) and unlisted modality (97039).

Date of Injury:

Procedure/service start date: 07/12/2005 – 10/05/2005

Number of days/visits requested: 71

DECISION: Upheld

IRO MCMCllc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 09/06/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The 71 visits to therapy for ultrasound 97035, manual therapy 97140, an unlisted modality 97039, and self-care management 97535 are not medically necessary.

CLINICAL HISTORY:
This 25-year-old male sustained a laceration to the dorsum of the left thumb on The wound was debrided and closed. Dr. Gutierriez referred him to Dr. Owen who evaluated him on 06/20/2005.

REFERENCE:
Green's Textbook of Operative Surgery: Chapter on Extensor Tendon Lacerations.

RATIONALE:
On examination the injured individual had no active extension of his thumb. He had no sensory changes. On 06/22/2005 he underwent repair of the extensor tendon under general anesthesia (GA). The operative note does not identify the exact tendon that was lacerated. He was placed in a thumb spica splint.

The next day Dr. Owen documented that the injured individual had active flexion and active extension. He was said to have a 15 to 20 degree arc of motion. He was placed back in the splint and was to begin "band-aid care" the next day. On 06/28/2005 he was said to have 20 to 25 degree arc of motion and active extension. There is no mention of any sensory loss.

On 07/19/2005 he had 10 degrees of hyperextension at the interphalangeal (IP) joint but lacked 5 to 10 degrees in comparison with the contralateral hand. Flexion of the IP joint was 35 to 40 degrees. The range of motion (ROM) at the metacarpophalangeal (MP) joint was from neutral extension to 40 degrees of flexion. His sensibility to soft touch was said to be "normal." On 08/09/2005 he had 0 to 40 degrees ROM of the MP joint and +5 to 45 degrees of ROM at the IP joint. He had been allowed to return to light duty.

On 10/06/2005 he was now said to lack 10 to 15 degrees of hyperextension. It is not clear if this is at the IP joint, however the ROM was said to be well within the normal range. There was a trace of tightness at the MP joint. Grip strength was said to be excellent. He was released from care and allowed to use his hand without restriction.

The letter of appeal of denial of additional time at each treatment session dated 01/09/2006 stated various principles of treatment of tendon injuries. It does not provide objective data to substantiate the additional time. The exercises that were taught to the injured individual that required the use of putty certainly did not require additional time. The daily treatment record does not include specific measures of the ROM from 06/29 to 10/15/2005. The exercise log also does not include any objective measurements.

The injured individual was receiving ultrasound, myofascial release, neuromuscular re-education and fluidotherapy. These modalities were not

required for the particular clinical situation. At best the injured individual needed occupational therapy (OT) twice a week for two weeks, then once a week for about four weeks and then once every other week for four weeks: total of ten sessions. These sessions should have been spent in teaching the injured individual a proper home exercise program and cautioning him about the need to avoid stressing the repair.

DATES RECORDS RECEIVED:
Records received and consolidated 08/23/2006.

RECORDS REVIEWED:
- Notification of IRO Assignment dated 08/09/06
- MR-117 dated 08/09/06
- DWC-60
- MCMC: IRO Medical Dispute Resolution M5 Retrospective Medical Necessity dated 08/23/06
- MCMC: Statement dated 08/10/06
- South Texas Rehabilitation and Hand Therapy: Check dated 08/16/06
- Dorinda Rodriguez, OTR: Letter dated 01/09/06 with attached "General PM&R Guidelines"
- Kip Owen, M.D.: Office notes dated 10/06/05, 09/08/05, 08/09/05, 07/19/05, 06/28/05, 06/23/05, 06/20/05
- South Texas Rehabilitation & Hand Therapy: Reports dated 10/05/05, 09/07/05, 08/02/05 from Dorinda Rodriguez, OTR, CHT
- South Texas Rehabilitation & Hand Therapy: Progress Notes dated 10/05/05, 09/07/05, 08/02/05
- South Texas Hand Therapy: Referral forms dated 09/08/05, 08/30/05, 07/25/05, 06/28/05
- South Texas Hand Therapy: Splint Evaluations dated 07/25/05, 07/14/05, 06/29/05 from Dorinda Rodriguez, OTR
- South Texas Hand Therapy: Information entitled, "Insensibilizar" dated 07/21/05
- Texas Mutual: Explanation of Benefits with DOS 07/12/05 through 10/05/05
- Occupational Therapy Treatment & Exercise Logs for the periods 07/06 to 08/03, 08/09 to 09/07 and 09/20 to 10/05
- South Texas Rehabilitation: Daily Treatment Records dated 06/29/05 through 10/05/05
- Doctors Hospital At Renaissance: Operative Report dated 06/22/05 from Kip Owen, M.D.
- Hand and Upper Extremity Rehabilitation – A Practical Guide, Third Edition (cover page and Chapter 20)
- South Texas Hand Therapy: Undated information entitled, "Splint Instructions"
- **South Texas Hand Therapy: Information entitled, "Putty Exercises"**

The reviewing provider is a Licensed/Boarded Orthopedic Surgeon and certifies that no known conflict of interest exists between the reviewing Orthopedic Surgeon 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 prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.

This decision by MCMC is deemed to be a Division decision and order (133.308(p) (5).

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.

In accordance with Division rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of DWC on this

28th day of September 2006.
Signature of IRO Employee: _____
Printed Name of IRO Employee:_____