

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestors Name and Address Ryan Potter, M. D. 5734 Spohn Dr. Corpus Christi, TX 78414	MDR Tracking No.: M5-05-2646-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Service Lloyd's Insurance Company, Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
6-17-04	11-30-04	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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. The amount due the requestor for the medical necessity issues is \$247.92.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit \$247.92, consistent with the applicable fee guidelines plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

Donna Auby

8-26-05

Authorized Signature

Typed Name

Date

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

August 18, 2005

CASE MANAGER
TEXAS WORKERS COMP. COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ____
EMPLOYEE: ____
POLICY: M5-05-2646-01
CLIENT TRACKING NUMBER: M5-05-2646-01

AMMENDED REVIEW - 8/24/05

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIoA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIoA for independent review.

Records Received:

Records from the State:

Notification of IRO Assignment, 7/7/05
Notice of receipt of request for Medical Dispute Resolution, 7/7/05
Medical Dispute Resolution Request/Response form
List of providers
Table of disputed services
Explanation of benefits

Records from Dr. Williams:

Letter requesting information, 7/7/05
New patient visit notes, 10/18/01
Established patient visit notes, 5/2/02, 5/23/02, 7/16/02

Records from Respondent:

Letter from Robert Josey, 7/12/05
Letter requesting information, 7/7/05
Peer review, William Blair Jr., MD, Occupational Orthopaedics Specialists, 8/13/03
Payment of Compensation or Notice of Refused/Disputed Claim forms

Records from Requestor

New patient office visit, 10/18/01
History and Physical, 11/2/01
Office note, Ryan Potter, 11/5/01
Operative report, 12/6/01
Medical Consent form, 1/11/02
Request for information, Shirley Lawson, RN, 1/11/02
Office visit notes, Scott Howell, MD, 2/5/02, 4/23/02
Letters from Ryan Potter, MD, 2/7/02, 4/11/02, 4/19/02
CT Scan report, lumbar spine, 4/10/02
Operative report, 4/10/02
History and Physical, Ryan Potter, MD, 4/18/02, 7/31/02, 3/10/03, 8/19/03, 10/14/03, 11/25/03, 8/10/04, 11/30/04, 12/23/04, 12/25/05
Office note, Thomas-Spann Clinic, 6/20/03, 1/16/04
Peer review, William Blair Jr., MD, Occupational Orthopaedics Specialists, 8/13/03
Radiology report, 9/3/03
Operative report, 11/4/03

Summary of Treatment/Case History:

The patient is a 45 year-old male with date of injury of ____, in which he injured his neck and shoulders. The patient began to complain of low back pain, as noted in 10/01. The MD's (Dr. Williams) initial note of 10/01 states it has been present for 8 years. Dr. Potter's initial exam (11/01) states that the patient noticed low back pain and leg pain after lifting a garage door. MRI of 8/01 and 9/03 showed degenerative disc disease (DDD), L3 annular tear, and bulges. The initial diagnosis was degenerative disc disease (DDD) and the treatment plan was for a discogram. This was done in 4/02 and showed tears at L3-L5 with concordant pain at L4. An L4-S1 fusion was recommended but has not been done. Lumbar ESIs and PT were done with minimal relief over the years. His last ESI was in 2/04.

The patient was seen 4 times during the reviewed time frame of (6/04 to 11/04). He is receiving medication management with narcotics and neurontin for back and leg pain.

Questions for Review:

1. Review the office visits (#99213) for dates of service 6/17/04 - 11/3/04 for medical necessity.

Explanation of Findings:

The patient has a diagnosis of lumbar DDD based on his date of injury of ____. The IME report indicates he originally injured his neck and shoulder and his back pain did not occur until months later. His MRI showed essentially age related DDD.

The patient's last ESI was in 2/04. The patient was seen 4 times during the reviewed time frame of (6/04 to 11/04). He is receiving medication management with narcotics and neurontin for back and leg pain.

Conclusion/Decision to Certify:

1. Review the office visits (#99213) for dates of service 6/17/04 - 11/3/04 for medical necessity.

The office visits (#99213) for the dates of 6/17/04 – 11/3/04 are medically necessary as this patient is receiving narcotic and non-narcotic medications for his ongoing low back pain. The patient requires MD follow up to determine success of treatment, compliance with treatment, any change in functional status, etc. These office visits are medically necessary in the treatment of this patient.

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

Criteria used are common practice among osteopathic and pain physicians.

References Used in Support of Decision:

1. Bonica's Management of Pain, third edition copyright '00.

The physician providing this review is board certified in Anesthesiology and is a doctor of Osteopathy. The reviewer is currently an attending physician at a major medical center providing anesthesia and pain management services. The reviewer has participated in undergraduate and graduate research. The reviewer has been in active practice since 1988.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.