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:	MDR Tracking No.: M5-06-0062-01
H. Ashley Ledger, DPM 806 E. Avenue D, Suite E Copperas Cove, TX 76522	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's. Position summary from the Table of Disputed Services states, "The suture that should have absorbed never did causing this patient great pain. After all other attempts to alleviate her pain were unsuccessful, the doctor had to remove all retained sutures."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included the TWCC 60 form. Position summary states, "Please direct all future correspondence regarding this Medical Dispute matter to the undersigned."

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)
1-19-05 – 3-1-05	CPT code 99212, 73600/RT, 20552, J1100, J3301, 20680/RT	☒ Yes ☐ No	$516.05
3-1-05	HCPCS code A550	☐ Yes ☒ 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 prevail on the majority of the disputed medical necessity issues. Since the carrier did not assign a relative value unit for HCPCS codes J1100, J3301 in accordance with Rule 134.202 (c)(6), recommend reimbursement as billed. The amount due the requestor for the items denied for medical necessity is $516.05.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.304 (i) (1-4), 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 carrier must refund the amount of the IRO fee ($650.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of $516.05. 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.

Findings and Decision and Order by:

		11-07-05
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.

October 17, 2005

TDI, Division of Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-06-0062-01
TWCC#:
Injured Employee: ___
DOI: ___
SS#: ___
IRO Certificate No.: IRO 5055

Dear Ms. ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 before referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Podiatric Surgery, and is currently on the DWC Approved Doctor List.

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,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-06-0062-01
___

Information Provided for Review:
DWC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
Office Notes 01/19/05 – 04/05/05
OR Report 03/01/05

Clinical History:
The brief clinical history concerns a patient who saw the podiatrist in question, evidently some time after an Achilles tendon repair surgery on her right lower extremity. She was complaining of continued pain and discomfort in the area of the surgery site.

Disputed Services:
Office visit, X-ray, injections, removal of implant and surgical trays.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion all the services in dispute stated above except the surgical trays were medically necessary in this case.

Rationale:
As of the visit dated January 19, 2005, the reviewer disagrees with the determination of the insurance carrier in this case. The patient clearly has a complaint of swelling and pain and his assessment and performing an x-ray was well within the medical standard of care for evaluation of a patient who is post surgical. As for the injection and office visit on February 9, 2005, I disagree with the determination of the insurance carrier in this case. The patient was continuing to have pain. The physician felt that it was possibly related to scar tissue or some possible nerve entrapment and injection for the treatment of this is well accepted as the standard in most medical textbooks. As far as the office visit dated February 23, 2005, I disagree with the determination of the insurance carrier in this case. This is a followup visit after injections and is a standard of care for evaluation of a patient post injection. The determination was also made at this point to take the patient to surgery and evaluation of the patient would be a reasonable step well within the medical standard of care. As of the operative report and billed surgical procedures March 1, 2005, I partially agree with the determination of the insurance carrier in this case. The following rationale is that I believe that a suture reaction, which is a well-documented potential complication of surgery, most likely did occur and that pain from non-absorbed stitches is a well-documented finding and surgical removal of those sutures would be well within the standard of care. However, the podiatrist in question billed a 20680, which is removal of a deep implant and the stitches were originally absorbable and do not fall within the parameter of a deep implant. Based on the operative note and the earlier note, which state they were originally supposed to be bio-absorbable stitches, the correct code would be 20520-removal of a foreign body in muscle or tendon sheath, simple. It is clear that the Achilles tendon was not violated itself and I believe that a total of 4 knots were most likely removed based on the operative report. I do not think that the surgical tray fee would be standard or should be reimbursed.

The patient clearly had complications and was having subjective complaints after the surgery. The podiatrist followed appropriate treatment, evaluation, attempt at injectional therapy prior to more aggressive therapy, followup evaluation after injection, and then proceeding onto surgery. In addition to my professional experience, I did not utilize any particular text. The case in question does not require a specific medical literature or study as treatment offered is well within accepted standard of care.