



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: Southwest Center Medical 7125 Marvin D. Love # 107 Dallas, Texas 75237	MDR Tracking No.: M5-06-0589-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: United States Fire Insurance Box 53	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: DWC-60 dispute package
POSITION SUMMARY: Per the table of disputed services "services are medically necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: Response to DWC-60
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-22-05	99213 and 99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$83.31
02-02-05	99214	<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 majority of the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1)

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 reimbursement in the amount of \$83.31. 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:

01-18-06

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

**10817 W. Hwy. 71
Phone: 512-288-3300**

**Austin, Texas 78735
FAX: 512-288-3356**

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 1/13/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0589-01
Name of Patient:	
Name of URA/Payer:	Southwest Center Medical
Name of Provider:	Southwest Center Medical
<small>(ER, Hospital, or Other Facility)</small>	
Name of Physician:	William Dodge, MD
<small>(Treating or Requesting)</small>	

January 5, 2006

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the

medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

CLINICAL HISTORY

Records submitted for review included:

- TWCC forms including TWCC 73 forms;
- A case review by Dr. Harney on 1/17/05;
- Clinic notes from Dr. Padron; and
- Various administrative forms.

Mr. ___ sustained an injury on ___. After failing conservative treatments and epidural steroid injections, he underwent surgery. He had prior back surgeries as well. In 8/04, an epidural implant was placed and he obtained moderate relief.

REQUESTED SERVICE(S)

99213 office visit, 99080-73 form completion and 99214 established patient visit.

DECISION

Approve 99213 and 99080-73. Deny 99214.

RATIONALE/BASIS FOR DECISION

This patient has had a complicated and tortuous course since his initial injury. He was seen by his physician on 3/22/05 for an appropriate follow-up. The documentation supports the 99213 level of services billed and a TWCC-73 form was completed to justify the 99080-73 charge. Mr. Eitel's prior visit was 2/2/05 and his follow-up visit after 3/22/05 was 7/22/05. The next scheduled visit was for 6 months later. These intervals are certainly appropriate for a chronic pain patient on narcotic medication indefinitely and who has an epidural implant. Therefore, the office visit and form completion are approved.

The code 99214 is for an established patient visit and requires at least 2 out of 3 of the following components: 1) a detailed history, 2) a detailed examination, and 3) a medical decision making of moderate complexity. The criteria to meet this level of coding was not supported by the progress note on 2/2/05. therefore, the office visit is denied.

CPT 2005, AMA publication.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider 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 IRO.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell