



## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity

#### PART I: GENERAL INFORMATION

**Type of Requestor:** (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:

Ryan N. Potter, M. D.  
5734 Spohn Drive  
Corpus Christi, Texas 78414

MDR Tracking No.: M5-06-1656-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

St. Paul Fire and Marine Insurance, Box 05

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

Position summary states, "Physician saw the patient for an office visit for his compensable injury. According to the TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documentation:

1. EOB
2. Payment information - Print Screen #0093274211

No Position Summary received.

#### 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)
11-01-05	99213 denied by the Respondent as W-9	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0

#### PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity issues. However, the Respondent has provided a print screen showing that this service has been reimbursed by the respondent. The Requestor sent an e-mail stating that she received this payment.

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

Texas Labor Code 413.011 and 413.031  
28 Texas Administrative Code Sec. 134.1, 134.202, 134.304

**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 not entitled to additional reimbursement.

Findings and Decision and Order by:

8-29-06

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.**

NOTICE OF INDEPENDENT REVIEW DECISION

July 5, 2006

Program Administrator  
Medical Review Division  
Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100, MS 48  
Austin, TX 78744-1609

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M5-06-1656-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Anesthesiology which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1990. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained a work related injury on \_\_\_ resulting in complaints of low back pain. The patient has been treated with medications, surgery, epidural steroid injections, and implantation of an intrathecal morphine pump.

### Requested Service(s)

Office visit (99213) on 11/01/05

### **Decision**

It is determined that office visit (99213) on 11/01/05 was medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

Following the implantation of the intrathecal morphine pain pump, the patient's first office visit was 10/12/05. The next office visit was 2 weeks later, 11/01/05, which was appropriate to follow up on the results of the pump increase and the oral medication changes. A 2 week follow up after any major change in intrathecal pain pump dosing would be considered medically appropriate and necessary and it was in this case. The level 3 (99213) established patient visit was appropriate, and the documentation supported this charge. The next office visit was 11/22/05 at an appropriate 3 week interval for a pump refill. It is noted that following this pump refill visit, the patient resumed a standard every 30 day office visit regimen.

This decision by the IRO is deemed to be a DWC decision and order.

### **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,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

### **Information Submitted to TMF for Review**

**Patient Name:** \_\_\_\_\_ **Tracking #:** M5-06-1656-01

#### **Information Submitted by Requestor:**

- Office visit and procedure notes from Dr. Potter
- Operative Note
- History and Physical from Christus Spohn Hospital
- Operative Reports

**Information Submitted by Respondent:** \_\_\_\_\_ None