



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

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.: M5-06-1657-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Fidelity and Guaranty Insurance Company, Box 19

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 healthcare to treat the compensable injury."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No DWC-60 response was received. The "Notice of Medical Dispute Resolution" statement was signed by the agent of the Respondent on 5-16-06.

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)
9-14-05	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
	Total		\$61.89

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. The amount due the Requestor for the items denied for medical necessity is \$61.89.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 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 \$61.89. 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:

Authorized Signature

Typed Name

7-20-06

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, 2005

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 #: M5-06-1657-01
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 ___ when he was lifting boxes and began to notice pain in his right shoulder, cervical spine, and right arm. The patient underwent chiropractic treatments, physical therapy, and facet blocks.

Requested Service(s)

Office visit (99213) on 09/14/05

Decision

It is determined that the office visit (99213) on 09/14/05 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has a history of right supraspinatous tendonitis and resulting chronic right shoulder pain, as well as a history of cervical radiculopathy of the right upper extremity secondary to underlying cervical disc bulges. The medical record documentation indicates that the patient did not see Dr. Potter in 2005 until the date of service in question, 09/14/05. On this date, the patient presented with a chief complaint of right shoulder pain. An appropriate history and physical were performed and an assessment and plan concluding supraspinatous tendonitis and possible shoulder injections was documented. Based on this patient's history, prior response to treatment, and continued complaints, the office visit on this date was medically reasonable and necessary and the level 3 (99213) established patient charge was appropriate and sufficiently documented.

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 #:** M5-06-1657

Information Submitted by Requestor:

- **Letters from Dr. Francis**
- **Medical Dispute Resolution Findings and Decision**
- **Notice of Independent Review**
- **Chiropractic Notes**

- Procedure Notes
- History and Physical
- Office notes from Dr. Joselevitz
- Medical evaluation from Dr. Maker
- Neurological Notes from Dr. Santos
- Emergency record from Christus Spohn
- Clinical notes from Bayshore Medical Center
- Office notes from Dr. Potter
- Nerve conduction study
- Reports of MRIs of cervical and thoracic spine
- Office notes from Dr. Baker
- Upper extremity impairment evaluation
- Office notes from Evans chiropractic
- Decision Letters
- X-ray reports of cervical spine
- MRI report of the right shoulder
- Request for Reconsideration
- X-ray report of right shoulder
- Letter from Dr. Samaniego
- Letter from Dr. LeCompte

Information Submitted by Respondent: _____ None