



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:

Ronald O. Washington, M. D.
831 S. R. L. Thornton Freeway
Dallas, TX 75203

MDR Tracking No.: M5-06-1962-01

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

Position summary (Table of Disputed Services) states, "Medical Interlocutory Order. Denial of medical payments after reconsideration after interlocutory order."

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Dates of service are prior to PRME Order and remain disputed in accordance to peer review recommendations. No add'l allowance 7-31-06."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. Interlocutory Order
3. EOB's

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)
7-25-05 – 11-15-05	99215 (\$150.00 <MAR x 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$600.00
	Total Due		\$600.00

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 prevail on the disputed medical necessity issues. Per Rule 134.202(d)(2) the amount due the Requestor for the items denied for medical necessity is \$600.00.

Dates of service 5-19-03 through 6-20-05 per Rule 133.308(e)(1) were not timely filed and are ineligible for review.

Date of service 1-17-06 was withdrawn by the Requestor in a telephone call with Dr .Washington on 10-25-06.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.202
Texas Labor Code Sec. § 413.011(a-d), 413.031

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 \$600.00. The Division hereby **ORDERS** the Respondent 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

10-27-06

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

September 14, 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 #: M5-06-1962-01
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 Internal Medicine 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 1996. 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 when she was kicked in the left ankle by a student which resulted in a broken left ankle. After healing the patient complained of continued persistent pain. The patient has been treated with medications, a pain management program, and injections.

Requested Service(s)

CPT code 99215-office visits billed from 07/25/05 through 01/17/06.

Decision

It is determined that the CPT code 99215-office visits billed from 07/25/05 through 01/17/06 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient continued to experience significant pain and mental anguish. The patient was prescribed Soma which appeared to help her condition. Prescribing this medication required that the patient be followed up on a regular basis by a physician in order to ensure that her pain had been controlled and to monitor for any potential side effects of long-term usage. Therefore, the CPT code 99215-office visits billed from 07/25/05 through 01/17/06 were medically necessary.

his 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

GBS:dm

Information Submitted to TMF for Review

Patient Name: ____ Tracking #: M5-06-1962-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- Table of disputed services
- Initial Functional Capacity Evaluation
- Office notes from Dr. Stephenson
- Office notes from Dr. Brodsky
- Office notes from Dr. Vera
- Letter from Dr. Graham
- Office notes from Dr. Graham
- Office notes from Dr. Beavers
- Record review by Argus
- Reconsideration
- Results of MRI of the left ankle
- Required Medical Examination
- Required Medical Examination-Addendum
- Electrodiagnostic Results
- Office notes from Dr. Fowler
- Subsequent Medical Report
- Medical Reports from Dr. Washington
- Request for Reconsideration
- Review decision from Prime
- Office notes from Dr. Strain
- Explanation of Benefits