



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	
Requestors Name and Address: Ryan Potter, M.D. 5734 Spohn Dr. Corpus, Christi, TX 78414	MDR Tracking No.: M5-06-2138-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Old Republic Insurance Company Box 02	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per Requestor's Table of Disputed Services: " According to the 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."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: Respondent did not submit a Position Summary to MDR.

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
4. Explanation of Benefits

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04/12/06	99213 & 20553	<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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION FINDINGS AND DECISION

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 not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

11-02-06

Authorized Signature

Typed Name

Date of Findings and Decision

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

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-2138-01
Name of Patient:	
Name of URA/Payer:	Ryan Potter, MD
Name of Provider: (ER, Hospital, or Other Facility)	Comprehensive Pain Management
Name of Physician: (Treating or Requesting)	Patrick Thomas

October 26, 2006

An independent review of the above-referenced case has been completed by a 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

DOCUMENTS REVIEWED

1. IRO Paperwork
2. Letter from Dr. Kennedy dated 8-23-05
3. Clinical notes from Dr. Potter
4. Cervical spine MRI reports from 3-2-04
5. Procedure notes for ESI, facet blocks, TPI, rhizotomy
6. Multiple TWCC 73 and TWCC 69 forms
7. Denial letters for repeat Botox and repeat trigger point injections
8. Progress notes from Dr. Snowden, DC
9. DOE by Dr. Thompson from 12-9-05
10. 2 Acupuncture articles
11. TWCC General Principles reprint

CLINICAL HISTORY

Mr. ___ sustained injuries from a work related MVA on ___. He apparently had a prior MVA on ___ with subsequent

treatment which resolved his symptoms. He had an MRI of his cervical spine on 3-2-04 which revealed multiple disc protrusions, spondylosis, and facet disease. Of note is that the MRI is prior to the current claim and all of the significant pathology is on the left side while his current complaints are on his right side. For his current symptoms, he underwent extensive treatment including medications, work restrictions, physical therapy, a muscle stimulator, chiropractic treatment, trigger point injections, acupuncture, facet injections, epidural steroid injections, and rhizotomy on multiple levels. Dr. Kennedy felt the patient reached MMI by 8-23-05 but Dr. Potter disagreed. The TWCC 69 form dated 12-13-05 by Dr. Thompson states the patient reached MMI on 12-9-05 with a 3% impairment rating. A TWCC 69 form on 7-11-06 by Dr. Snowden states MMI reached on 7-5-06 with an impairment rating of 5%. Dr. Potter filed a TWCC 69 form dated 9-7-05 that states the patient could return to work with no restrictions on 9-8-05.

REQUESTED SERVICE(S)

Office visit 99213, 20553- Single MX trigger point

DECISION

Denied

RATIONALE/BASIS FOR DECISION

Mr. ___ sustained acute injuries to his neck and upper back from a MVA on ___ super imposed on pre-existing degenerative disc disease and facet disease. He received lengthy and exhaustive conservative treatment as well as invasive procedures including ESI, TPI, and rhizotomy. Generally, his acute injuries should respond to the above measures and resolve 2-3 months after his MVA. This viewpoint is accepted standard of care and supported by the Philadelphia Panel, ACOEM and CMS guidelines as well as standard textbooks. Furthermore, the patient had at least 2 trigger point injections in the past with only temporary relief so further TPI are not medically necessary or supported in this patient.

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, 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.

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