



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	
Requestor's Name and Address:	MDR Tracking No.: M5-06-2187-01
Ryan Potter, M.D. 5734 Spohn Drive Corpus Christi, TX 78414	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Texas Municipal League Intergovernmental Risk Box 19	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: As stated on Requestor's Table of Disputed Services, "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. Explanation of Benefits
3. CMS 1500's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent states: "The Self-insured denied reimbursement as this office visit was not reasonable and necessary to cure and relieve the effects of the compensable low back strain which occurred on ____."

Principle Documentation:

1. Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05/05/06	99213	<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, 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:

Medical Dispute Officer

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.

Clear Resolutions Inc.

An Independent Review Organization

3616 Far West Blvd. Suite 337-117

Austin, TX 7831

November 10, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee _____

TDI-DWC #: _____

MDR Tracking #: _____

IRO #: _____

M5-06-2187-01

5327

Clear Resolutions, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to Clear Resolutions for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

Clear Resolutions has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The Reviewer is on the DWC Approved Doctor List (ADL). The Clear Resolutions Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including but not limited to: notes from Ryan Potter MD, notes from Scott Walker DC, notes from Consuelo Harwood MD, notes from John Obermiller MD, peer review from Brian Buck MD.

CLINICAL HISTORY

A brief history is given from the notes. This is a 61 year-old female who reported low back pain and leg spasms related to driving a bus on ____.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of office visit on 5/05/06.

DETERMINATION / DECISION

The Reviewer agrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

The Reviewer is in agreement with the peer review from Brian Buck MD, in that based on the history of the injury and the ICD-9 codes given, this would be a self-limiting diagnosis and would resolve prior to the disputed date of service. The disputed service of 99213-office visit would not be reasonable or medically necessary according to the *Texas Guidelines for Quality Assurance and Practice Parameters* and *The Official Disability Guidelines*. The disputed date of service occurred almost one-year post injury rendering the disputed service medically unnecessary according to the treatment parameters of the above criteria for the diagnosis codes given.

Screening Criteria

1. Specific:

- Texas Guidelines for Quality Assurance Practice Parameters
- Official Disability Guidelines

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

Clear Resolutions has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Clear Resolutions has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Clear Resolutions Inc., I certify that there is no known conflict between the Reviewer, Clear Resolutions and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Clear Resolutions is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,
Clear Resolutions Inc.



Chris Crow
President & Chief Resolutions Officer

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. 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.

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

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 10th day of November, 2006.

Name and Signature of Clear Resolutions Inc. Representative:

Sincerely,
Clear Resolutions Inc.

Chris Crow
President & Chief Resolutions Officer