



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 Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Ryan Potter, M.D. 5734 Spohn Drive Corpus Christi, Texas 78414	MDR Tracking No.: M5-07-0003-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: St. Paul Fire & Marine Insurance Rep Box # 05	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Requestor's Position Summary: Per the Table of Disputed Services "Rationale A: 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."

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: The Respondent did not submit a Position Summary

Principle Documentation:

1. No response submitted by the Respondent

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-23-06	99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$45.06
<b>TOTAL DUE</b>			

#### 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.

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

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

**PART VII: DIVISION FINDINGS AND ORDER**

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 entitled to reimbursement in the amount of \$45.06. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$650.00. 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 Order**

01-09-07

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Findings and 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.**

# 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:	M5-07-0003-01
Name of Patient:	
Name of URA/Payer:	Ryan Potter, MD
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Victor Kereh, MD

December 12, 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. Letter from the Hartford Management Center denying requested services on 07-28-06
2. Clinical notes from Dr. Potter including procedure notes for spinal cord stimulator and intrathecal pump
3. TWCC forms

### CLINICAL HISTORY

Mr. \_\_\_\_ sustained a work related injury on \_\_\_\_\_. He had extensive treatments including medication, facet blocks, ESI's, rhizotomy, spinal cord stimulator, intrathecal pump, and two spinal surgeries. Apparently, he had an Impairment Rating of 19%.

### REQUESTED SERVICE(S)

99212- OV OTPT

DECISION

Approve

RATIONALE/BASIS FOR DECISION

Mr. \_\_\_ is a chronic pain patient who is still experiencing significant pain after two spinal surgeries. He currently has an intrathecal pump and has routine follow-ups to monitor his medication use. Clinical notes from Dr. Potter from 01-11-05 through 09-06-06 indicate an appropriate pattern of routine follow up visits. Regular visits for chronic pain patients are appropriate and medically necessary. This viewpoint is supported by standard of care, standard textbooks, peer review literature, and generally accepted guidelines including ACOEM, Philadelphia Panel study, and CMS. Therefore the requested services are approved.

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