



## 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 Potter, M. D.  
5734 Spohn Drive  
Corpus Christi, Texas 78414

MDR Tracking No.: M5-07-0057-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Box 17

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: "Physician saw the patient for an office visit for her 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."

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, "There simply is no medical documentation to substantiate the medical necessity for the treatments provided by Requestor... In conclusion, the Requestor should not be entitled to any reimbursement for the disputed treatments or services as they failed to provide any documentation to support the medical necessity of the office visits."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. 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)
10-11-05	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
	Total Due		\$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 disputed medical necessity issues. Per Rule 134.202(c)(1) 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, 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 \$61.89. 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:

Medical Dispute Officer

12-04-06

Authorized Signature

Typed Name

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.



November 22, 2006

Re: MDR #: M5 07 0057 01 Injured Employee:  
DWC #: DOI:  
IRO Cert. #: 5340

April 14, 2002

**TRANSMITTED VIA FAX TO:**  
**TDI, Division of Workers' Compensation**

Medical Dispute Resolution  
Fax: (512) 804-4868

**RESPONDENT:**

**TREATING DOCTOR: Ryan Potter, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the president of ZRC Medical Resolutions, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in physical medicine and rehabilitation and is currently listed on the DWC Approved Doctor List.

This decision by ZRC Medical Resolutions, Inc. 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, 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.

Sincerely,

Jeff Cunningham, DC  
President

P.O. Box 855  
Sulphur Springs, TX 75483  
903.488.2329 \* 903.642.0064 (fax)



**REVIEWER'S REPORT**  
**M5 07 0057 01**

**MEDICAL INFORMATION REVIEWED:**

1. The documents submitted by the requestor, Ryan Potter, M.D. consist of medical examinations, followup evaluations, and injection procedure notes from Dr. Potter beginning on 01/07/03 and consisting primarily of monthly office visits up through the most recent followup on 09/20/06.
2. Medical records submitted by the respondent, Downs Stanford, D.C., consist of the same requestor's records in addition to medical records from Steven C. Canion, D.C., neurologist Frank P. Bonikowski, M.D., Michael G. Fuentes, M.D., physical therapy with the Doctors Clinic, peer review by Michael Edmond, M.D., peer review by Mike O'Kelley, D.C., physical therapy at Rehab One Physical Therapy, required medical

examination with John P. Obermiller, M.D., Adame Chiropractic, designated doctor examination by Juan Felipe Santos, M.D., as well as numerous imaging diagnostic treatment reports.

BRIEF CLINICAL HISTORY:

The records indicate that this lady was hit on the head by a metal object while she was working, sustaining primarily neck pain and headaches. She received extensive chiropractic care, physical therapy, diagnostic studies, and has been treated for a period of almost 4 years by Dr. Potter with prescription medication and a variety of invasive pain management injections.

DISPUTED SERVICES:

There is 1 disputed services that is indicated for a clinical office visit examination, CPT code 99213, for date of service 10/11/05 in the amount billed of \$115.00 and with a medical fee guideline payment value of \$61.89.

DECISION:

I DISAGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:

Following review of the medical information submitted by both the requestor and the respondent, I disagree with the carrier's determination that this medical examination is not medically reasonable and necessary and agree with the requestor that the disputed date of service, 10/11/05, was medically reasonable and necessary. The medical rationale for this reviewer's decision is based on the treatment provided by Dr. Potter for a period of approximately 4 years including frequent procedures and ongoing prescription medications. At the time of the 10/11/05 date of examination, it was noted that the patient was being seen for refill of pain medication, Lortab, indicating that with the use of the Lortab, her pain scale was 3/10. The patient was assessed for the effectiveness and necessity and monitoring of the prescription medication. Determination was to refill medication and see patient in 1 month. Both immediately before the 10/11/05 date of examination, 09/12/05, as well as immediately following, 11/08/05, the patient was under active medical care including ongoing injections and prescription medication. As the physician has the responsibility to monitor ongoing utilization of prescription medication for the treatment of chronic pain, and as the patient was continuing to receive regular injections including facet injections, Dr. Potter had the medical responsibility to see the patient on a regular basis, which would reasonably be monthly, in order to comply with the Texas State Board of Medical Examiners guidelines and rules for proper monitoring by a physician prescribing narcotic medication for the treatment of nonmalignant chronic pain.

SCREENING CRITERIA/TREATMENT GUIDELINES UTILIZED:

In addition to normal screening procedures, the primary treatment guideline for the necessity of physician office visits to monitor the utilization and ongoing prescription of narcotic medication for patients with nonmalignant chronic pain, the rules from the Texas State Board of Medical Examiners is utilized and referred to.