



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

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.: M5-07-0064-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: St. Paul Fire and 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: Physician saw the pt 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 to MDR.

Principle Documentation: The Respondent did not respond to the 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)
11-22-05	99213-25	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
11-22-05	62368	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$67.30
11-22-05	95991	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$100.09
11-22-05	J2275	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Reimbursement recommended per Rule 134.202(c)(6)
	TOTAL DUE		\$229.28 and reimbursement per Rule 134.202(c)(6)

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 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 \$229.28 and reimbursement per Rule 134.202(c)(6). 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 by:

05-23-07

Authorized Signature

Medical Dispute Resolution Officer

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.

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

PH. 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 18, 2006

Re: IRO Case # M5-07-0064 -01

Texas Department of Insurance, Division of Workers' Compensation:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Division of Workers' Compensation cases. Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that the Division of Workers' Compensation assign cases to certified IROs, this case was assigned to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management, and who has met the requirements for the Division of Workers' Compensation Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. Notes, Dr. Potter 1/05 – 9/06

History

The patient has lumbar radiculopathy, with pain persisting after various injection procedures, surgery and failure of spinal cord stimulation. An intrathecal catheter / pump system was implanted on 8/25/05.

Requested Service(s)

OV, analyse spine infusion pump, refilling administered by physician.

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The Medtronic implanted pump has a drug reservoir which must be refilled periodically. At the refill, the pump is reprogrammed. The refill interval depends on the concentration and dose of drug, but monthly refills are appropriate, and would be necessary as long as the pump is functioning.

This medical necessity decision by an Independent Review Organization is deemed to be a Worker's Compensation decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have a right to appeal the decision. The decision of the Independent Review organization is binding during the appeal process.

If you are disputing a decision other than a spinal surgery prospective decision, the appeal must be made directly to the district clerk in Travis County (see Texas Labor Code sec. 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.

Daniel Y. Chin, for GP