



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

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.: M5-07-0194-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	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): "Physician saw the patient for an office visit for their compensable injury. According to 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/Position Summary
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "Harris and Harris represents _____ in this matter. Please direct all future correspondence regarding this Medical Dispute matter to the undersigned..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary

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)
8-18-06	99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$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. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 Division has determined that the Requestor is not entitled to reimbursement of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

Medical Dispute Officer

01-08-07

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.

INDEPENDENT REVIEW INCORPORATED

December 8, 2006

Re: MDR #: M5 07 0194 01 Injured Employee:
DWC #: DOI:
IRO Cert. #: 5055

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 IRI for an independent review. IRI

has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 office manager of Independent Review, 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 Independent Review, 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

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

I N D E P E N D E N T R E V I E W I N C O R P O R A T E D

REVIEWER'S REPORT

M5 07 0194 01

MEDICAL INFORMATION REVIEWED:

1. Office notes from Dr. Potter with specific reference to the 08/18/06 note
2. Report dated 07/08/06 from Dr. Tsourmas
3. Report from Dr. Robinson on 07/26/04
4. Report from Dr. Lenderman on 04/16/04
5. Report from Dr. Vaughn dated 02/03/04
6. Notes from Dr. Votzmeyer, chiropractor
7. Notes from Dr. Kareh dated 09/29/03
8. MRI scan report of the cervical spine dated 09/24/03 showing multilevel degenerative changes
9. Note from Dr. Green dated 09/05/03
10. Notes from Dr. Fuentes
11. X-ray report of the cervical spine dated 02/03/00
12. MRI scan report of the right knee dated 12/23/02
13. MRI scan report of the thoracic spine dated 10/14/03

BRIEF CLINICAL HISTORY:

It appears as though the patient slipped and fell at work on _____ sustaining an injury to her cervical spine.

DISPUTED SERVICES:

99213-office visit denied for medical necessity for the date of service August 18, 2006.

DECISION:

I AGREE WITH THE DETERMINATION MADE BY INSURANCE CARRIER IN THIS CASE.

RATIONALE OR BASIS FOR DECISION:

I do not believe that the office visit of 08/18/06 is causally related to the events of The visit of 08/18/06 was the last in a sequence of 3 visits that took place on 06/02/06, 07/19/06, and 08/18/06. Prior to June 2006, she had not been seen since 04/13/05, and prior to 08/13/05, she had not been seen since 04/15/04. The records do not establish a continuum of care specifically related to the cervical spine that would establish causation with respect to the original slip-and-fall incident at work on

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED:

This determination is based strictly on the history and the records reviewed. Causation requires a continuation of treatment and/or maximum medical improvement documented by continuing medical documentation, neither of which existed for the time frame immediately prior to the 08/18/06 visit as detailed above.