



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

Requestors Name and Address: Ryan Potter, M. D. 5734 Spohn Drive Corpus Christi, Texas 78414	MDR Tracking No.: M5-07-0366-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: ACE AMERICAN INSURANCE CO, BOX 15	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 their 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, "...Ongoing treatment is not reasonable and necessary as relates to the compensable injury... Carrier has also filed Plain Language 11, Extent of Injury dispute on 10-30-06..."

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?	Amount Due
1-18-06, 2-20-06, 3-27-06	99213 (\$61.63 x 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	See note below.
4-7-06	99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	See note below.

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.

In a letter dated 1-03-07 CPT code 99212 on 4-26-06 was withdrawn by the Requestor. The IRO referenced this service as occurring on 4-28-06. This service will not be a part of this review.

Regarding the Respondent's Position Summary that a "Plain Language 11" was filed: There is insufficient evidence to determine if treatment was to the disputed conditions. The diagnosis codes on the CMS 1500 are: 724.2- LUMBAGO, 724.5- UNSPECIFIED BACKACHE, 724.4- THORACIC/LUMBOSACRAL NEURITIS/RADICULITIS. The peer review was performed several months after the dates of service in dispute in this review.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity issues. All services were denied for both medical necessity and "45-Charges exceed your contracted/legislated fee arrangement." Review of the dispute revealed that the Requestor had a PPO contract from January – April, 2006. The Respondent should reimburse the Requestor per the PPO contract.

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 reimbursement per Focus Network Contract effect at the time services were rendered. 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.

Decision and Order:

04-04-07

Dispute Officer

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.

ZRC MEDICAL RESOLUTIONS

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification & QA
Division (HWCN) MC 103-5A
Via Fax: 512.804.4868

02/13/07

RE: IRO Case #: M5.07.0366.07
Name: _____
Coverage Type: Workers' Compensation Health Care - Non- network
Type of Review:
 ____ Preauthorization
 ____ Concurrent Review
 XX Retrospective Review
Prevailing Party:
 XX Requestor
 ____ Carrier

ZRC Medical Resolutions, Inc. (ZRC) has been certified, IRO Certificate #5340, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to ZRC for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

ZRC has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, ZRC reviewed the medical records and documentation provided to ZRC by involved parties.

This case was reviewed by an M.D., board-certified neurologist in the private practice of Adult Neurology for 20 years with experience in both quality assessment and resource management that spans some 12 years. The reviewer 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 (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of ZRC, I certify that:

1. there is no known conflict between the reviewer, ZRC and/or any officer/employee of ZRC with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on 02/13/07.

RIGHT TO APPEAL:

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,
Jeff Cunningham, DC.
President/CEO

REVIEWER'S REPORT

DATE OF REVIEW: February 11, 2007

IRO CASE #: M5-07-0366-01

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Relates to the medical necessity for office visits dated 01/18/06, 02/20/06, 03/27/06, 04/07/06, and 04/28/06. These office visits were CPT coded as either 99213, 99214, or 99212.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board-certified neurologist in the private practice of Adult Neurology for 20 years with experience in both quality assessment and resource management that spans some 12 years

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. MRI scan of the lumbar spine, which was dated 10/108/04
2. Arterial Doppler of the left lower extremity of 10/14/04
3. Plain lumbar spine films, a left hip film, left lower leg films, as well as a left knee film obtained on 10/15/04
4. Medical records provided of comprehensive pain management for the dates in dispute
5. Operative notes for lumbar epidural steroid injections
6. Neurosurgical consultation

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient in question is a 52-year-old male who was injured during his normal course of work on _____. Since that time the patient has undergone several investigational studies as well as generally conservative treatment for this condition.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

I disagree with the prior findings on the disputed services on the basis of the limited information I have. It is not clear to me that other providers are following this patient. He is on medications and is receiving intermittent treatments in the form of epidural steroid injections and remains symptomatic. Since he is on medications, this does require intermittent follow-up. A dispute may arise as to whether the medical documentation meets the level of services provided, although this is not the question. Additional considerations may be the frequency of the visit, but again, this is not the question. Since that doctor who received this adverse determination is the person who is managing his medical regimen, then it is reasonable that he receive periodic follow-ups. While there are other issues that may be disputed as noted above, the medical necessity of follow-up is not in question in this case.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPR-Agency for Healthcare Research & Quality Guidelines.
- DWC-Division of Workers' Compensation Policies or Guidelines.
- European Guidelines for Management of Chronic Low Back Pain.
- Interqual Criteria.
- XX Medical judgement, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)