

**TEXAS WORKERS' COMPENSATION COMMISSION
 MEDICAL REVIEW DIVISION, MS-48
 MEDICAL DISPUTE RESOLUTION
 FINDINGS AND DECISION**

MDR Tracking Number: M5-04-1504-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on June 6, 2003.

In accordance with Rule 133.307(d)(1) A dispute on a carrier shall be considered timely if it is filed with the division no later than one year after the dates of service in dispute therefore dates of service 01-02-02 through 06-04-02 in dispute are considered untimely and will not be addressed in this review.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Hydrocodone/acetaminophen 10/325, #100, Methocarbamol 750 mg, #100, Hydrocodone/acetaminophen 10/325, #500 and Levaquin 750 mg, #50 for 08-09-02 and 12-18-02 were found to be medically necessary. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 21, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Neither the requestor nor the respondents submitted EOB's for the services rendered on dates listed below. The carrier did not provide a valid basis for the denial of the services listed below and therefore will be reviewed in accordance with 1996 MFG. However, the requestor failed to provide convincing evidence of carrier receipt of the requestor's initial request for reimbursement of incurred out of pocket expenses in accordance with rule 133.307(f)(3), therefore reimbursement is not recommended for all dates of service listed on table below.

DOS	CPT CODE	Billed	Paid	EOB Denial Code
09-04-02	683-505-00 C683-206-00	\$10.00	\$0.00	No EOB
10-02-02	C685-163-00 685-164-00 685-162-00	\$10.00 \$10.00 \$30.00	\$0.00	No EOB

11-04-02	687-554-00 C687-543-00	\$10.00 \$10.00	\$0.00	No EOB
12-20-02	B691-212-00	\$30.00	\$0.00	No EOB
01-22-03	C693-676-00	\$10.00	\$0.00	No EOB
DOS	CPT CODE	Billed	Paid	EOB Denial Code
02-11-03	C695-746-00	\$10.00	\$0.00	No EOB
02-12-03	B695-890-00	\$30.00	\$0.00	No EOB
03-05-03	C695-889-01	\$10.00	\$0.00	No EOB
04-03-03	700-415-00	\$10.00	\$0.00	No EOB
04-09-03	B700-934-00	\$30.00	\$0.00	No EOB
04-28-03	702-513-00	\$10.00	\$0.00	No EOB
TOTAL			\$210.00	

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 08-09-02 and 12-18-02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this day of October 2004.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:
MDR Tracking Number: M5-04-1504-01

Name of Patient:	
Name of URA/Payer:	City of Houston
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Jose Reyes, Jr., MD
(Treating or Requesting)	

June 15, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurology. 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 Texas Workers' Compensation Commission 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: Texas Workers Compensation Commission

CLINICAL HISTORY

Records Reviewed: Operative reports, lumbar epidural steroid injections by Dr. Reyes 11/23/98, 12/7/98, and 12/14/98, lumbar facet operative report, lumbar facet injections Dr. Reyes 2/16/99, lumbar myelogram report 10/19/2000, Pain Management Consultants evaluation and follow-up visits, assorted. Post-operative follow-up visit Eric H. Scheffey, MD 12/18/02 (post laminectomy and fusion with instrumentation).

Mr. _____injured at 43 years of age doing heavy lifting trying to accommodate a walk-behind mower in the back of a pickup. Initially felt to

have mechanical low back pain. After only temporary relief from lumbar ESI's and lumbar facet blocks, the patient apparently underwent lumbar laminectomy with fusion and instrumentation 12/16/02. He has apparently continued to have pain.

REQUESTED SERVICE(S)

Hydrocodone/acetaminophen 10/325, #100. Methocarbamol 750 mg. #100.
Hydrocodone/acetaminophen 10/325, #500. Levaquin 750 mg. #50.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

It is apparent from even the relatively few records sent that this patient has a chronic pain syndrome. Dr. James Hood (from follow-up office visit of Jose Reyes, Jr., MD of 12/24/04) felt that the patient would "probably need medications for the rest of his life." When administered under properly monitored medical conditions the hydrocodone/acetaminophen and methocarbamol would represent a reasonable regimen for managing this patient's chronic pain. It appears that the Levaquin 750 mg. is being used for possible/probably post-operative wound infection documented on the patient's post-operative follow-up visit with Eric Scheffey, MD on 12/18/02. This patient appears to have a chronic pain syndrome which is most likely going to need long term medication management.