



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: () Health Care Provider (X) Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-0066-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Zurich American Insurance Company Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation provided: TWCC-60 and receipts for prescriptions purchased. Position summary: Request that I be reimbursed for my out of pocket expenses.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation provided: Response to TWCC-60 and copy of peer review. Position summary: Carrier is denying the remaining services in dispute based on peer reviews denying the medical necessity or reasonableness of the services in dispute in relation to the injury of over 8 years ago.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-4-03 to 8-21-04	Carisoprodol and Hydrocodone	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

Per Rule 133.308(e)(1) dates of service 01-20-03 through 08-27-03 were not timely filed and will not be a part of the review.

On 09-01-05, 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.

CPT code 99213 dates of service 01-14-04 through 02-19-04 were listed on the table of disputed services. Per Rule 133.308(f)(2) the requestor did not submit the written notices of adverse determinations. No reimbursement is recommended.

Ombudsman Assistance: An unrepresented injured worker may be assisted by a Commission Ombudsman at the State Office of Administrative Hearings. To request Ombudsman assistance please call 512.804.4176 or 1.800.372.7713 ext 4176.

Asistencia por parte del Ombudsman: Un trabajador lesionado puede obtener asistencia por parte de un Ombudsman de la Comision en un procedimiento ante la Oficina Estatal de Audiencias Administrativas (sigla SOAH). Para pedir asistencia de un Ombudsman, favor de llamar a 512.804.4176 o al 1.800.372.7713.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 133.308(f)(2)

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 for the services involved in this dispute.

Findings and Decision by:

Authorized Signature

09-19-05

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.

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:	M5-05-0066-01
Name of Patient:	
Name of URA/Payer:	Zurich American
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	John White, MD

August 31, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. 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

Documents submitted for review included:

- Progress notes from Dr. White;
- A FCE at Sneakers Rehab on 2/26/02;
- Peer Review from Dr. Fuller on 1/23/04; and
- Peer Review from Dr. Brock on 7/9/02.

Ms. ____ sustained a work related injury during a moving vehicle accident (MVA) on _____. She had extensive evaluations and treatments with suboptimal results. The treatments included chiropractic care, medications, physical therapy, biofeedback, and the PRIDE program. She underwent trigger point injections, facet injections, and ESIs. A progress note from Dr. White on 7/11/04 documents "less than adequate relief."

REQUESTED SERVICE(S)

Medical necessity of RX (carisoprodol and hydrocodone) for dates of service 9/4/03 and 8/21/04.

DECISION

Denied. The requested medications are not medically necessary for this time frame.

RATIONALE/BASIS FOR DECISION

The reviewed records show Ms. ____ developed a chronic pain syndrome after an MVA on _____. Generally, narcotics and muscle relaxants of the type requested are not indicated for chronic pain syndromes because of potential long term side effects, potential dependence or addiction issues and the availability of safer alternative medications and modalities. This view is community standard and

supported by National Guideline Clearinghouse, ACOEM, and Washington State Dept. of Labor and Industries Guidelines to name just a few. No records were submitted to show an attempt to taper these medications or try alternative, non-addicting medicines like NSAIDS, Cox-2, or Ultram for example. Also, these documents do not reveal any objective or even subjective evidence that these medications are improving her function, job status, or quality of life. For these reasons, these medications are not medically necessary for this patient during this time period.