

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

|  |  |
|--|--|
| <b>Type of Requestor:</b> ( ) HCP (X) IE ( ) IC              | <b>Response Timely Filed?</b> (X) Yes ( ) No |
| Requestor's Name and Address                                 | MDR Tracking No.: M5-05-0806-01              |
|  | TWCC No.:                                    |
|  | Injured Employee's Name:                     |
| Respondent's Name and Address      Rep Box 19<br><br>c/o FOL | Date of Injury:                              |
|  | Employer's Name:                             |
|  | Insurance Carrier's No.:                     |

### PART II: SUMMARY OF DISPUTE AND FINDINGS

| Dates of Service |          | CPT Code(s) or Description   | Did Requestor Prevail?  |
|------------------|----------|------------------------------|---|
| From             | To       |                              |   |
| 4-24-04          | 10-30-04 | Rx for hydrocodone/ibuprofen | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

### PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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.

### PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

**Findings and Decision by:**

\_\_\_\_\_  
Authorized Signature \_\_\_\_\_  
Date

### PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**PART VI: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and the TWCC Chief Clerk of Proceedings/Appeals Clerk must receive it within 20 days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representative's box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

# IRO America Inc.

## An Independent Review Organization

(IRO America Inc. was formerly known as ZRC Services Inc. DBA ZiroC)

**7626 Parkview Circle**

**Austin, TX 78731**

Phone: 512-346-5040

Fax: 512-692-2924

July 13, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: \_\_\_\_\_

TWCC #: \_\_\_\_\_

MDR Tracking #: M5-05-0806-01

IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission (TWCC) has assigned this case to IRO America for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed MD, board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **RECORDS REVIEWED**

Notification of IRO assignment, information provided by Requestor, Respondent, and Treating Doctor(s) including:

1. Cervical MRI 07/23/01
2. Cervical Post Myelogram and CT scan 02/04/02
3. TWCC Report of Medical Evaluation 08/12/02
4. Operative Report 9/20/02
5. Cervical Spine notes, 10/22/02, 01/06/03
6. Follow up notes, Dr. Vazquez-Seoane 01/16/03, 02/27/03, 03/31/03, 06/02/03, 07/09/04, 08/11/03, 01/07/04, 03/01/04, 06/02/04, 09/01/04, 12/01/04
7. CT Cervical Spine 07/31/03
8. Dr. Gonzales Letter 12/17/03, 07/02/04
9. Intracorp Advisor Review, Dr. Graham 01/30/04
10. Physical therapy modality sheet 02/04-02/16/04
11. Physical therapy discharge note 03/31/04
12. Dr. Gonzales Follow-up notes, 04/02/04, 07/02/04
13. Table of disputed services 04/30/04 – 10/30/04
14. Claim Rep Letter to Claimant 08/05/04
15. Dr. Taylor Review 09/02/04
16. Prescription Record 03/09/05
17. Medical Dispute Resolution Request and Response 05/23/05
18. Letter Claims Rep 05/26/05
19. Letter for a Second Request for Reimbursement

### **CLINICAL HISTORY**

The patient is a 41 year old right hand dominant female with a reported injury on \_\_\_ due to repetitive trauma from bending and pulling fryers off an assembly line. An MRI of the cervical spine dated 07/23/01 showed marginal osteophytosis and uncovertebral hypertrophy at the C5-6 and C6-7 causing bilateral neural foraminal narrowing at the C5-6 level and to the left of C6-7. A cervical myelogram and CT scan performed on 02/04/02 indicated an arachnoid cyst and a slight bulge of the C5-6 disc with no evidence of root impingement. Dr. Gutzman completed a medical evaluation on 08/12/02 and determined the patient had reached maximum medical improvement as of 08/30/01 with a five percent disability rating with the diagnosis of cervical disc displacement and synovitis.

The patient underwent an anterior C5-6 discectomy with an anterior interbody fusion at C5-6 with an allograft and instrumentation. Consecutive cervical x-rays done on 10/22/02 and 01/06/03 showed that the fusion was in good alignment. Despite postoperative interventions, the patient continued with neck and arm pain, accompanied with tingling in her arms and hands when seen on 06/02/03. A CT of the cervical spine was recommended. Results dated 07/31/03 indicated a post C5-6 anterior interbody fusion with apparent maturity and no evidence of complication were noted.

Records from Dr. Graham on 01/30/04 and Dr. Taylor on 09/02/04 were reviewed for questions of relatedness.

### **DISPUTED SERVICE(S)**

Under dispute is the retrospective medical necessity of RX 00093101501 Hydrocodone/ibuprofen.

### **DETERMINATION/DECISION**

The Reviewer agrees with the determination of the insurance carrier.

### **RATIONALE/BASIS FOR THE DECISION**

The Reviewer reviewed the materials that were submitted and specifically prescription 00093101501 for Vicoprofen. The Reviewer agrees that the Vicoprofen is not medically necessary for this condition. The patient had reached maximum medical improvement. Her symptoms were at a plateau and she was not likely to show significant further improvement with the Vicoprofen. Her ongoing symptomatology was really related to disease of life and not her work injury. There was no objective medical indication for her symptoms, no indication for ongoing treatment, and the Vicoprofen itself was excessive treatment not likely to lead to significant improvement.

#### **Screening Criteria**

1. Specific:

Orthopedic Knowledge Update The Spine, Chapter 32

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by TWCC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

**CERTIFICATION BY OFFICER**

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**