MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: ( ) HCP (X) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address ___	MDR Tracking No.: M5-05-1484-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Interstate Insurance, Box 01	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**		
2-12-04	**8-30-04**	**Oxycontin**	☐ **Yes** ☒ **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.

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 peude 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

Findings and Decision by:

	Donna Auby	8-19-05
Authorized Signature	Typed Name	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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

PROFESSIONAL
ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:	___
IRO CASE NUMBER:	M5-05-1484-01
NAME OF REQUESTOR:	___
NAME OF PROVIDER:	David Hagstrom, M.D.
REVIEWED BY:	Board Certified in Orthopedic Surgery
IRO CERTIFICATION NO:	IRO 5288
DATE OF REPORT:	08/12/05

Dear Mr. ___:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Orthopedic Surgery and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates 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 any of the treating physicians or providers or any

of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An evaluation with Robert V. Carr, M.D. dated 03/27/01
A follow-up evaluation with Dr. Carr dated 04/19/01
A Designated Doctor Evaluation by Donald L. Wehmeyer, M.D. dated 04/25/01
An evaluation with an unknown provider (the signature was illegible) dated 04/27/01
A letter "To Whom It May Concern" dated 04/30/01 from Dr. Wehmeyer
An operative procedure dated 05/08/01 from David Hagstrom, M.D. for a cervical epidural steroid injection (ESI) and trigger point injections times two
Follow-up evaluations with Dr. Carr dated 05/17/01 and 06/14/01
Follow-up evaluations with Dr. Hagstrom dated 09/12/01, 11/07/01, 12/01/01, and 02/22/02
Prescriptions for Oxy IR 5 mg. and Oxycontin 20 mg. dated 12/01/01 from Dr. Hagstrom
Another operative procedure note for a cervical ESI dated 06/04/02 from Dr. Hagstrom
Additional follow-up visits with Dr. Hagstrom dated 07/09/02, 08/19/02, and 01/27/03
Another procedure note for a cervical ESI dated 07/18/02 from Dr. Hagstrom
Prescriptions for Oxy IR 5 mg. and Oxycontin 40 mg. dated 07/18/02, 04/14/03, 05/08/03, 06/10/03, 07/08/03, 08/11/03, 09/11/03, and 10/14/03
Notes from Dr. Hagstrom's office dated 05/20/03 and 06/09/03 noting the claimant did not show up for his appointments
A TWCC-21 (Notice of Refused/Disputed Claim) dated 11/05/03
Additional prescriptions for Oxycontin 20 mg. from Dr. Hagstrom dated 11/13/03, 12/12/03, 01/07/04, 02/09/04, 03/08/04, 04/06/04, 05/12/04, 06/15/04, and 07/20/04
A letter "To Whom It May Concern" from Dr. Hagstrom dated 04/28/05

Clinical History Summarized:

On 03/27/01, the claimant informed Dr. Carr he was scared of surgery regarding his neck and did not want to do that and wanted further pain management. He was referred for an impairment rating and to Dr. Hagstrom. On 04/25/01, Dr. Wehmeyer, the Designated Doctor, placed the claimant at Maximum Medical Improvement (MMI) on 10/14/99 and assigned the claimant a 34% whole person impairment rating. The claimant received cervical ESIs from Dr. Hagstrom on 05/08/01, 06/04/02, and 07/18/02. On 12/01/01, 07/18/02, and 04/14/03, Dr. Hagstrom prescribed the claimant Oxycontin and Oxy IR. The claimant received additional prescriptions of Oxycontin from Dr. Hagstrom on 05/08/03, 07/08/03, 08/11/03, 09/11/03, 10/14/03, 11/13/03,

12/12/03, 01/07/04, 02/09/04, 03/08/04, 04/06/04, 05/12/04, 06/15/04, and 07/20/04. A TWCC-21 form was filed on 11/05/03, disputing the extent of injury to include degenerative disc disease, as it was a disease of life. On 04/28/05, Dr. Hagstrom addressed a letter "To Whom It May Concern". He noted the claimant's medications helped him control his chronic and disabling pain condition, which included Oxycontin, Oxy IR, Ambien, and Zanaflex. Dr. Hagstrom noted the claimant had not been seen since 2003, but stated it was imperative for him to continue his pain medications for maintenance purposes and quality of life existence. His letter was to serve an absolute letter of medical necessity.

Disputed Services:

The use of Oxycontin from 02/12/04 through 08/30/04

Decision:

I agree with the insurance carrier, as the use of Oxycontin from 02/12/04 through 08/30/04 was not reasonable or necessary.

Rationale/Basis for Decision:

There was no documentation to support the use of Oxycontin in that time period. The claimant was not seen by any treating physician for a period of over two years. There was no evidence that his pain complaints were due to the compensable injury, which was in fact a disease of life. Therefore, in my opinion, it was neither reasonable nor necessary for the claimant to receive Oxycontin from 02/12/04 through 08/30/04.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk **within twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 08/10/05 from the office of Professional Associates.

Sincerely,

_____
Lisa Christian
Secretary/General Counsel