



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

PREVAILING PARTY DETERMINATION

PART I: GENERAL INFORMATION

Type of Requestor: () Health Care Provider (X) Injured Employee () Insurance Carrier

Requestor's Name and Address: _____	MDR Tracking No.: M5-05-1632-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Continental Casualty Company, Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: 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 Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Consistent with the requirements in Rule 133.308, the Division has reviewed the IRO decision and determined:

- The requestor is the prevailing party.
 The respondent is the prevailing party.

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 III: ADDITIONAL INSTRUCTIONS

The parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines.

Issued by:

Donna Auby

9-8-05

Authorized Signature

Typed Name

Date of Order



Barton Oaks Plaza Two, Suite 200
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NOTICE OF INDEPENDENT REVIEW DECISION

September 1, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-05-1632-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Orthopedic Surgery which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1979. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for

ndependent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The 43 year old male injured his low back and left leg on ____ while lifting heavy objects in his place of employment. He has been treated with medications and therapy.

Requested Service(s)

Oxycontin for dates of service of 09/22/2004 through 02/02/2005

Decision

It is determined that the Oxycontin for dates of service of 09/22/2004 through 02/02/2005 was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient suffered a lumbosacral strain injury in _____. He was evaluated and treated appropriately. The evaluation revealed degenerative disc disease at L4-L5 with herniated nucleus pulposus and degenerative disc disease at L5-S1. The patient suffers intermittent worsening of his symptoms despite his current dosage of Oxycontin. The Oxycontin is not medically necessary and alternate methods of pain relief should be instituted to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." The signature is written in a cursive, somewhat stylized font.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

Information Used by TMF in Decision

Patient Name: _____

TWCC ID #: M5-05-1632-01

Medical record documentation provided:

- **Progress Notes**
- **Functional capacity evaluation**
- **Diagnostic Tests**
- **Impairment Rating**
- **Peer Reviews**