

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: () HCP (X) IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address	MDR Tracking No.: M5-05-2395-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Employers Mutual Casualty Company Box 19	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		
03-04-04	01-07-05	Hydrocodone/APAP, Carisoprodol and Oxen-EC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input 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.

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 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.

Findings and Decision by:

Authorized Signature

Typed Name

06-28-05

Date of Decision

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 it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) 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 Representatives 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.

Envoy Medical Systems, LP

1726 Cricket Hollow

Austin, Texas 78758

Phone 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 21, 2005

Re: IRO Case # M5-05-2395-01 ___ amended 6/24/05

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting 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 referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. History and physical, 5/11/04, Dr. Brownhill
4. Report, 3/18/04, Dr. August
5. Texas Pain Institute reports, Dr. Nguyen and associates
6. CT scan lumbar spine report, 1/28/05
7. Lumbar spine x-ray report, 7/16/04

History

The patient is a 37-year-old male who in ___ was lifting and pushing a trailer when he developed back pain. The pain continued despite medications and rest. MRI, discographic and EMG evaluation indicated surgically correctable pathology in the lumbar spine. On 9/28/01 surgery was carried out, including a posterior lumbar interbody fusion with decompression and instrumentation, along with a posteriolateral fusion. The patient improved gradually to the point that in late 2002 he was able to return to work, after work hardening and physical therapy. He was given lifting restrictions at work. The patient continues to use a significant amount of medication for pain, despite a 1/28/05 lumbar CT scan that showed the fusion to be in good position with nothing to suggest a reason for discomfort.

Requested Service(s)

Hydrocodone/APAP, Carisprodol, Oxen EC

Decision

I agree with the carrier's decision to deny the requested medications.

Rationale

I agree with the denial of what was a rather large amount of pain medication, muscle relaxants and anti-inflammatories. There are no findings on follow up studies that would indicate that there are problems secondary to the patient's surgery, and the patient improved to the point that he could return to work.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

Daniel Y. Chin, for GP