

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address  _____t	MDR Tracking No.: M5-05-2849-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  University of Texas System, Box 46	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY SERVICES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
6-9-04	6-9-04	Hydrocodone/APAP	<input checked="" 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.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if they are filed with the division no later than one year after the dates of service in dispute. The following dates of service are not eligible for this review: 5-30-02 through 3-4-04.

Regarding date of service 2-17-05: The requestor did not submit convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B).

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues. The total due the requestor for the medical necessity services is \$22.25.

**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 AND ORDER**

The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines totaling \$22.25, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Donna Auby

8-31-05

Authorized Signature

Typed Name

Date of Order

**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.



Barton Oaks Plaza Two, Suite 200  
901 Mopac Expressway South • Austin, TX 78746-5799  
Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

## NOTICE OF INDEPENDENT REVIEW DECISION

August 26, 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: \_\_\_t  
MDR Tracking #: M5-05-2849-01  
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 physical medicine and rehabilitation 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 1981. 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 independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### **Clinical History**

This 37 year old female injured her back on \_\_\_ while lifting heavy objects, including water bottles, on a daily basis at her place of employment. She failed to improve and underwent a right sided hemilaminectomy for a large disc herniation at L4-5 levels in October of 1997.

### **Requested Service(s)**

Hydrocodone/APAP 7.5 for the date of service of 06/09/2004.

### **Decision**

It is determined that the Hydrocodone/APAP 7.5 for the date of service of 06/09/2004 was medically necessary to treat this patient's condition.

### **Rationale/Basis for Decision**

The patient had persistent pain and underwent a series of epidural injections without success. An MRU in 2002 indicated a recurrent disc herniation with epidural scarring and possible left L5 root involvement. Many people oppose the use of opiates for chronic pain,

but there are many groups that support its use. The latter includes the American Pain Society, Texas Pain Society, American Academy

of Pain Medicine, and the American Academy of Pain Management. Reduction of pain itself can be a means of improved function. The amount of hydrocodone used by this patient is comparatively small compared to the amount used by patients with similar complaints of pain.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

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

GBS:vn

Attachment

### Information Used by TMF in Decision

Patient Name: \_\_\_t

TWCC ID #: M5-05-2849-01

**Medical record documentation provided:**

- **Pharmaceutical Notes**
- **Progress Notes**
- **Operative Notes**
- **Diagnostic Tests**
- **Designated Doctors Evaluation**
- **Impairment Rating**
- **Required Medical Examination**
- **Peer Review**
- **Consults**
- **Claims**