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

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity

PART I: GENERAL INFORMATION

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

Requestor's Name and Address:	MDR Tracking No.: M5-06-0310-01
___	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Continental Casualty Company, Box 47	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 package. Position Summary states, "Medically necessary for chronic pain."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 response. "The prescription medications claimant submitted for reimbursement are not medically necessary and are medically unreasonable to teat the compensable injury."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-22-04 – 7-20-05	Methadose, Hydrocodone/APAP	☐ Yes ☒ No	0

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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.

Dates of service 12-23-03 – 10-05-04 per Rule 133.308(e)(1) were not timely filed and are ineligible for review.

Regarding date of service 8-11-05: 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). Per Rule 133.308 (p)(5) an IRO decision is deemed to be a Division decision and order. Therefore, no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307 and 133.308

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Findings and Decision by:

	Donna Auby	2-27-06
Authorized Signature	Typed Name	Date of Findings and Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

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

February 23, 2006

Texas Department of Insurance Division of Texas Worker's Compensation
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-06-0310-01
DWC #:
Injured Employee:
Requestor:
Respondent: Continental
Maximus #: TW06-0013

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308, which allows for a dispute resolution by an IRO.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician who is board certified in anesthesiology on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns an adult male who had a work related injury on ___. The patient reported that while working as a phlebotomist, he was lifting and pulling a patient in the operating room when he experienced increase in back pain. Diagnoses included chronic low back pain, lumbar post laminectomy syndrome, depressive disorder, chronic back pain and spondylosis. Evaluation and treatment have included multiple surgeries, physical therapy, medications, pain management and behavioral medicine services.

Requested Services

Methadose and Hydrocodone/APAP from 11/22/04-7/20/05.

<u>Documents and/or information used by the reviewer to reach a decision:</u>

Documents Submitted by Requestor:

1. None Submitted.

Documents Submitted by Respondent:

1. Carrier's Letters – 2/2/06
2. Peer Review Determinations – 12/1/03, 3/31/04
3. Comprehensive Medical Analysis – 2005
4. Pikes Peak Physical Medicine Records – 1/11/99-3/17/03
5. Comprehensive Medical Analysis – 2002
6. Medical Reviews – 2/24/02, 4/14/05, 4/14/05
7. Physical Medicine and Rehabilitation Records – 1998-2002
8. Radiological Reports (e.g., MRIs, x-rays, etc) – 1993-2001
9. Operative Reports – 1996-2001
10. Orthopedic Records – 1995-2001
11. Colorado Sports & Spine Center Records – 1999-2000
12. Neuropsychiatry Records – 11/29/99
13. Hospital Records –1998-2004
14. Intracorp Records & Reports – 1996-1999
15. Behavioral Health Records - 2005

Decision

The Carrier's denial of authorization for the requested services is upheld.

Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

Rationale/Basis for Decision

The MAXIMUS physician consultant indicated that the patient sustained a work related injury while pulling a patient in the operating room and experiencing low back pain. The MAXIMUS physician consultant noted his diagnoses included chronic back pain, post laminectomy syndrome, and depressive disorder. The MAXIMUS physician consultant also noted treatment has included medical therapy, multiple surgeries, physical therapy, and behavioral pain management. The MAXIMUS physician consultant explained that a peer review analysis and comprehensive medical analysis concluded the patient suffered a lumbosacral strain that was superimposed on pre-existent degenerative disc disease at T11-12 and T12-L1. The MAXIMUS physician consultant indicated he continued to require increased medical therapy with Flexeril, Methadose (Methadone), and Hydrocodone/APAP for pain control. The MAXIMUS physician consultant noted a psychological evaluation reported the patient suffered from a significant depressive disorder and that his pain was more severe than that of the average healthy person. The MAXIMUS physician consultant also noted the patient was not compliant with a detoxification program to decrease his use of narcotic analgesics for pain control. The MAXIMUS physician consultant explained there is no evidence that the patient participated in a multi-disciplinary approach to pain control with cessation of the Methadone and Hydrocodone.

Therefore, the MAXIMUS physician consultant concluded that the Methadose and Hydrocodone/APAP from 11/22/04-7/20/05 were not medically necessary for treatment of the patient's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department