



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 Dispute

PART I: GENERAL INFORMATION

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

Requestor's Name and Address: Debbie Crawford, D.O. 3804 Highway 377 South Brownwood, Texas 76801	MDR Tracking No.:	M5-06-0493-01
	Claim No.:	
	Injured Employee's Name:	
Respondent's Name and Address: Box 45	Date of Injury:	
	Employer's Name:	
	Insurance Carrier's No.:	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package

POSITION SUMMARY: Per the table of disputed services "Services are medically necessary based on our documentation".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: No position summary received from Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04-04-05 to 07-20-05	99212 and 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$457.23
04-04-05 to 07-20-05	G0351, J2300, J2550, J0702, J1100, J2800, J7050, G0347, 20552 and J3590	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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 **majority** of the disputed medical necessity issues.

HCPCS codes J2300 and J2550 date of service 04-04-05 were paid by the carrier and will not be a part of the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

PART VII: DIVISION DECISION AND ORDER

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 entitled to additional reimbursement in the amount of \$457.23. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

Authorized Signature

12-21-05

Date of Order

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

CLARIFICATION 1/19/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0493-01
Name of Patient:	
Name of URA/Payer:	Debbie Crawford, DO
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Debbie Crawford, DO

December 14, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved

Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

CLINICAL HISTORY

Medical records reviewed

1. Administrative documents
2. EOB's
3. Operative report – Shoulder surgery
4. Progress notes David Stark, M.D.
5. MRI right shoulder
6. MRI left shoulder
7. Pain management progress notes Debbie Crawford, D.O.
8. RME Edward Brandecker, M.D.
9. Radiographs right shoulder
10. FCE
11. Determination of maximum medical improvement by Dr. Crawford.
12. Employers first report of injury

This is a 46 year old lady who reports that she sustained an injury to the left shoulder while doing laundry for the in _____. She was initially seen by Dr. Crawford the next day (12/4). One week later the claimant reports an injury to the right shoulder. Imaging studies noted some marginal degenerative changes. Orthopedic examination led to a shoulder arthroscopic surgery. Debridement was completed. Post-operative pain continued and a second surgery was performed. At the same time the claimant was under the care of Dr. Crawford who prescribed a variety of analgesics and performed multiple injections. After the date of injury, the care was complicated with co-morbidities of migraine headaches and changes to the cervical pap smear. Cervical MRI noted a disc bulge

with cord contact. Functional capacity evaluation noted a sub-optimal effort and that there were significant complaints of pain. The injection protocol started in December 2002. An RME by Dr. Brandecker diagnosed this as a shoulder strain (soft tissue myofascial lesion). Additional steroid injections and IM analgesic medications are noted in the records. In July 2003 a narcotic agreement was signed by the parties. Multiple injections, medications and modalities all to address the unrelenting complaints of pain. In May 2005 Dr. Wehmeyer completed a Designated Doctor assessment and determined statutory maximum medical improvement and assigned a 13% whole person impairment rating.

REQUESTED SERVICE(S)

Office visits; Therapeutic or DX injection; Injection Nalbuphine; Injection Promethazine; Injection Betamethasone; Injection Dexamethasone; Injection methocarbamol; Infusion normal Saline; Intravenous Injection for therapeutic Diagnosis related; Trigger point injections; unclassified biologics.

DECISION

Approve office visits.

Deny all other requested services.

RATIONALE/BASIS FOR DECISION

Office visits were found to be medically necessary for medication management.

Injection Nalbuphine. This is a particularly potent narcotic analgesic. The pathology noted on imaging studies and the findings noted at arthroscopy are not severe. The complaints of pain are far in excess of the objective parameters reported. The sequale of long term narcotic use far outweigh the temporary benefit.

Injection Promethazine - Promethazine is an antihistamine. It blocks the effects of the naturally occurring chemical histamine in your body. The use in this case is to potentiate the effects of the narcotic medications. In that there is no objective data of any efficacy if the narcotic or other medication resolving the problem after several years, this failure has to indicate that other treatment plans should be attempted. Repeating the same failed methodologies is not indicated.

Injection Betamethasone (aka Celestone) is a synthetic steroid used for anti-inflammatory properties. The intra-articular use should be limited and with the lack of response there is no indication to repeat.

Injection Dexamethasone (aka Decadron) another steroid medication. Please see above.

Injection methocarbamol (aka Robaxn) is a muscle relaxer medication. The injury was a shoulder strain and a rotator cuff lesion. There is nothing presented in the medical records indicating the need for this medication months after the surgery.

Infusion normal Saline not indicated.

Intravenous Injection for therapeutic Diagnosis related – unclear why or when this was completed.

Trigger point injections – the injury was intra-articular. The vague complaints of pain were not being addressed with this method. As noted in the ODG such injections do not have the efficacy to be effective. As noted in Archives of Physical Medicine and Rehabilitation (July 2001) it is the placebo effect of the needle as opposed to the medication instilled.

Weisel Text Principals of Orthopedic Medicine and Surgery
Official Disability Guidelines (ODG)
Archives of PM&R (July 2001)
PDR
E-Medicine.com

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell