



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

Table with 2 columns: Requestor/Respondent Name and Address, and various identification numbers (MDR Tracking No., Claim No., Date of Injury, 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, "I am requesting reimbursement for these medically necessary prescriptions."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response.

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

Table with 4 columns: Date(s) of Service, CPT Code(s) or Description, Medically Necessary?, and Additional Amount Due (if any). Rows include Carisoprodol, Hydrocodone, and Tramadol.

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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$265.68.

A PLN 11 was received by the Commission on 7-11-01. Review of the documents concerning a BRC on 11-14-01 and a CCH on 4-12-02 reveal that the services in this dispute have been adjudicated and found to be compensable.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.503

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 entitled to additional reimbursement in the amount of \$265.68. 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.

Findings and Decision and Order by:

Donna Auby, Medical Dispute Officer

5-30-06

Authorized Signature

Typed Name

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.

May 25, 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 #: M5-06-0791-01
DWC #: _____
Injured Employee: _____
Requestor: _____
Respondent: University of Texas
MAXIMUS Case #: TW06-0080

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 female who had a work related injury on _____. The patient reported she was injured while lifting heavy objects including bottles of water. Diagnoses included lumbar disc displacement, radiculopathy, status post discectomy, failed back syndrome and traumatic facet arthropathy. Evaluation and treatment have included medications, epidural steroid and facet injections, surgery, and physical therapy and use of a TENS unit.

Requested Services

Prescription medications (Hydrocodone, Caprisopodol, and Tramadol) from 3/29/05-9/6/05.

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

Documents Submitted by Requestor:

1. None submitted.

Documents Submitted by Respondent:

1. Prospective Medical Review – 1/11/06
2. Smithfield Clinic Records – 11/18/97
3. Diagnostic Studies (e.g., MRI, x-rays, etc.) – 10/6/97, 10/10/97, 4/20/01, 5/9/01
4. Orthopedic Records and Correspondence – 10/14/97-6/10/02
5. Seton Medical Center Records – 10/17/97
6. Spine, Neurosurgical and Rehabilitation Center Records – 4/20/01, 5/18/01
7. Retrospective Review – 12/6/01, 2/10/05
8. Required Medical Examination – 1/25/02
9. Pain Management Records and Correspondence – 6/20/02-7/29/03
10. South Austin Therapy Group Records – 7/11/02, 7/26/02
11. Garner Riley Physical Therapy Records – 9/5/02-9/23/02
12. Designated Doctor's Examination – 12/31/02
13. Center for Preventive, Occupational & Environmental Medicine Records - 3/2/04
14. Physical Medicine and Rehabilitation Records and Correspondence – 8/18/04-1/17/06
15. J. Lowell Haro, MD Records and Correspondence – 2/4/05

Decision

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

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 noted the patient has a work related chronic pain syndrome. The MAXIMUS physician consultant indicated She has no history of back pain prior to the work related injury in _____. The MAXIMUS physician consultant explained she had undergone extensive conservative and interventional therapies and was treated by multiple providers including a pain management specialist. The MAXIMUS physician consultant noted follow-up MRI in 2002 revealed multilevel degenerative changes that were worse at L4-L5, but problems at L2-L3, L3-L4 and L4-L5 as well. The MAXIMUS physician consultant indicated that her only surgical option was felt to be a lumbar fusion. The MAXIMUS physician consultant explained that her pain management specialist felt her pain required medical therapy and prescribed medications. The MAXIMUS physician consultant also explained that she underwent numerous interventions but continued with significant daily low back pain. The MAXIMUS physician consultant noted that at no time was her pain not felt to be directly related to the discogenic disc condition that was a direct result of the work injury on _____. The MAXIMUS physician consultant indicated that she had significant pain that required treatment with multiple medications in addition to interventions such as epidural steroid and facet injections. The

MAXIMUS physician consultant noted she had not been evaluated for surgical intervention. The MAXIMUS physician consultant explained that the prescribed medical therapy was medically necessary as it was prescribed by the treating provider in response to her subjective complaints of pain and objective diagnoses directly related to her work related chronic pain condition.

Therefore, the MAXIMUS physician consultant concluded that the prescription medications (Hydrocodone, Caprisopodol, and Tramadol) from 3/29/05-9/6/05 were medically necessary for treatment of the member's condition.

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Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department