



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

<b>Type of Requestor:</b> ( ) Health Care Provider (X) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  claimant	MDR Tracking No.: M5-06-1863-01 (former MDR # M4-06-4995-01 )
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TPCIGA For Reliance National Insurance Rep Box # 50	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.: 011655000256WC01

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: No position summary was submitted by the Requestor.

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. Copies of receipts for prescription medications paid for by the Requestor
3. Explanation of Benefits

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a position summary to MDR.

Principle Documentation: The Respondent did not submit a response to MDR.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-08-05 to 02-06-06	Norco, Oxycontin, Hydrocodone/APAP, Amoxicillin and Kadian	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
06-14-05, 07-29-05, 10-04-05, 11-22-05 and 02-06-06	Soma (\$355.41 X 5 DOS) (see information below regarding reimbursement calculations)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,777.05
09-09-05, 01-10-06 and 02-10-06	Migrazone (\$17.76 X 3 DOS) (see information below regarding reimbursement calculations)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$53.28
<b>TOTAL DUE</b>			<b>\$1,830.33</b>

#### 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.

Reimbursement per Rule 134.503(a)(2)(A) is as follows:

### **SOMA - Brand**

06-14-05:  $\$450.71$  divided by 100 (quantity) =  $\$4.51$  X 90 (quantity) =  $\$405.90$  X  $\$1.09$  =  $\$442.43$  +  $\$4.00$  dispensing fee =  $\$446.43$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$355.41$ .

07-29-05:  $\$450.71$  divided by 100 (quantity) =  $\$4.51$  X 90 (quantity) =  $\$405.90$  X  $\$1.09$  =  $\$442.43$  +  $\$4.00$  dispensing fee =  $\$446.43$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$355.41$ .

10-04-05:  $\$450.71$  divided by 100 (quantity) =  $\$4.51$  X 90 (quantity) =  $\$405.90$  X  $\$1.09$  =  $\$442.43$  +  $\$4.00$  dispensing fee =  $\$446.43$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$355.41$ .

11-22-05:  $\$450.71$  divided by 100 (quantity) =  $\$4.51$  X 90 (quantity) =  $\$405.90$  X  $\$1.09$  =  $\$442.43$  +  $\$4.00$  dispensing fee =  $\$446.43$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$355.41$ .

02-06-06:  $\$450.71$  divided by 100 (quantity) =  $\$4.51$  X 90 (quantity) =  $\$405.90$  X  $\$1.09$  =  $\$442.43$  +  $\$4.00$  dispensing fee =  $\$446.43$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$355.41$ .

### **MIGRAZONE – Generic**

09-09-05:  $\$43.86$  divided by 100 (quantity) =  $\$0.44$  X 40 (quantity) =  $\$17.60$  X  $\$1.25$  =  $\$22.00$  +  $\$4.00$  dispensing fee =  $\$26.00$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$17.76$ .

01-10-06:  $\$43.86$  divided by 100 (quantity) =  $\$0.44$  X 40 (quantity) =  $\$17.60$  X  $\$1.25$  =  $\$22.00$  +  $\$4.00$  dispensing fee =  $\$26.00$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$17.76$ .

02-10-06:  $\$43.86$  divided by 100 (quantity) =  $\$0.44$  X 40 (quantity) =  $\$17.60$  X  $\$1.25$  =  $\$22.00$  +  $\$4.00$  dispensing fee =  $\$26.00$  MAR. The Requestor is seeking less than MAR; therefore per Rule 134.202(d)(2) reimbursement is recommended in the amount of  $\$17.76$ .

## **PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1, 134.503(a)(2)(A) and 134.202(d)(2)  
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

## **PART VII: DIVISION FINDINGS 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 reimbursement in the amount of  $\$1,830.33$ . The Division hereby **ORDERS** the Respondent to remit this amount due at the time of payment to the Requestor within 30 days of receipt of this Order.

Order by:

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.**

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity  
IRO Decision Notification Letter**

<b>Date:</b>	10/24/2006 <b>Amended 10/25/2006</b>
<b>Injured Employee:</b>	
<b>MDR #:</b>	<b>M5-06-1863-01</b>
<b>DWC #:</b>	
<b>MCMC Certification #:</b>	<b>TDI IRO-5294</b>

**REQUESTED SERVICES:**

Requested procedure or service: Norco, Soma, OxyContin, Migrazone, Hydrocodone/APAP, Amoxicillin, and Kadian. Denied for medical necessity.

Dates of Service (DOS) 03/08/2005-02/10/2006

**DECISION: Partial**

IRO MCMCllc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

**Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 10/24/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:**

For DOS 03/08/2005 to 02/10/2006 the medications Norco, OxyContin, hydrocodone, Kadian, and Amoxicillin are not medically necessary. The medications Soma and Migrazone are medically necessary.

**CLINICAL HISTORY:**

The injured individual is a 48 year old male with a diagnosis of cervical Failed Back Surgical Syndrome (FBSS) from his 1999 Worker's Compensation (WC) injury. The injured individual also has a diagnosis of lumbar FBSS with severe complications that he cannot walk, is wheelchair bound, and completely disabled. While he may require narcotic pain medication for this lumbar pain, it is not possible to link it to his cervical or relate it to his cervical in any appreciable way, as his lumbar symptoms seem much worse. Prior reviews recommended non-narcotic management of his WC related pain (neck) and that is reasonable therefore continue the Soma and Migrazone and discontinue the narcotics.

**REFERENCE:**

Bonica's Management of Pain. Third edition. Copyright 2000.

**RATIONALE:**

The injured individual is a 48 year old male with date of injury 09/1999 followed by cervical surgery in 10/1999. The injured individual also

had subsequent lumbar surgery years later but lumbar has not been deemed compensable for him. He cannot walk and is in a wheelchair. He has been on OxyContin, Norco, and Soma for years. Recently, the OxyContin was not helping so Kadian was started. He has been advised on multiple peer reviews dating back to 2001 to wean off the narcotics and use only non-narcotic medication. It appears from the notes that his lumbar Failed Back Surgical Syndrome (FBSS) symptoms are at least as bad if not worse than his cervical. He has two pain sources (cervical and lumbar) so attributing all his medications to his neck Worker's Compensation injury is not possible. He had been advised for years to wean off his narcotics as far as his cervical compensability and that is reasonable. The Amoxicillin is an antibiotic he was on twice and there is no indication it is related to his neck. The Migrazone is for headache, which can occur after neck surgery so is reasonable; the Soma is for muscle spasms, which can occur after neck surgery and is also reasonable. Both are non narcotic.

**DATES RECORDS RECEIVED:**

Medicals received 09/28/2006.

**RECORDS REVIEWED**

- Notification of IRO Assignment dated 08/17/06
- MR-117 dated 08/17/06
- DWC-60
- DWC-62: Explanation of Benefits with Dates of Audit of 04/25/06, 01/23/06, 10/27/05, 09/20/05, 09/09/05
- MCMC: IRO Medical Dispute Resolution M5 Retrospective Medical Necessity dated 09/29/06
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 08/22/06
- Gallagher Bassett Serv: Check dated 09/27/06
- Texoma Neurology Associates: Report dated 01/31/06 from Jose Matus, M.D.
- Texoma Neurology Associates: Letter dated 01/31/06 from Jose Matus, M.D.
- IMED, Inc.: Peer Review Addendums dated 10/25/05, 05/01/05, 07/25/04, 03/09/04, 02/19/04, 11/10/03, 07/30/02 from Wayne Gordon, M.D.
- Leonard Pharmacy: Profile from 03/08/05 through 01/12/06
- Coats & Todd, P.C.: Report dated 08/08/01 from Dr. Callewart
- North Texas SpineCare: Clinic note dated 08/08/01 from Craig Callewart, M.D.
- IMED: Peer Review dated 03/14/01 from Wayne Gordon, M.D.
- Orthopedic Associates of Dallas: Work Status Reports dated 11/19/99, 11/??/9?, 10/??/9? (dates difficult to read)

The reviewing provider is a **Licensed/Boarded Pain Management/Anesthesiologist** and certifies that no known conflict of interest exists between the reviewing **Pain Management/Anesthesiologist** 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 prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.

This decision by MCMC is deemed to be a Division decision and order (133.308(p) (5).

**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, 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.

**In accordance with Division rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of DWC on this**

**25<sup>th</sup> day of October 2006.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** \_\_\_\_\_

**MCMC llc ▪ 88 Black Falcon Avenue, Suite 353 ▪ Boston, MA 02210 ▪ 800-227-1464 ▪ 617-375-7777 (fax)**

**[mcman@mcman.com](mailto:mcman@mcman.com) ▪ [www.mcman.com](http://www.mcman.com)**