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

Requestors Name and Address:	MDR Tracking No.: M5-06-1942-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
GREAT AMERICAN INS CO OF NEW YORK, Box 19	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "…I have also included a copy of the independent review from the TWCC. Please note the decision I have highlighted that find the hydrocodone and duragesic to be medically necessary."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "The current medical information submitted does not substantiate the need for the health care allegedly provided. Therefore, the request must be determined as not to be medically necessary. An IRO decision issued on December 12, 2002 does not support the need for healthcare services allegedly provided in 2004-2005."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary

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)
2-8-05 - 10-09-05	Hydromorphone, Fentanyl, Hydrocodone, Duragesic	☐ Yes ☒ No	$0.00
	Total Due		$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 disputed medical necessity issues. No reimbursement recommended.

Date of service 12-14-04 per Rule 133.308(e)(1) was not timely filed and is ineligible for review.

The Requestor submitted a copy of a review performed by an Independent Review Organization on 12-12-2002. However, this review does not pertain to the dates of service contained in the dispute currently under review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1, 134.502, 134.503, 134.504
Texas Labor Code Sec.§ 413.011(a-d), 413.031

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 reimbursement for the services involved in this dispute.

Findings and Decision by:

	Medical Dispute Officer	01-08-07
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.

ZRC MEDICAL RESOLUTIONS INC

December 27, 2006

Re:	**MDR #:**	**M5 06 1942 01**	**Injured Employee:**	___
	DWC #:	___	**DOI:**	___
	IRO Cert. #:	**5340**	**SS#:**	___

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **Great American Insurance**

TREATING DOCTOR: **Everton Edmondsen, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to ZRC Medical Resolutions for an independent review. ZRC has performed an independent review of the medical records to determine medical necessity. In performing this review, ZRC reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the president of ZRC Medical Resolutions, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in neurology and is currently listed on the DWC Approved Doctor List.

This decision by ZRC Medical Resolutions, Inc. is deemed to be a DWC decision and order.

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.

Sincerely,
Jeff Cunningham, DC
President

REVIEWER'S REPORT
M5 06 1942 01

A. MEDICAL INFORMATION REVIEWED:
Insurance records, copies of filled prescriptions and instructions for same, and Dr. Edmondsen's medical records,

B. BRIEF CLINICAL HISTORY:
The patient is a now 50 yo male who was injured in an unspecified manner on or about ___. The patient has had chronic lower back pain and neck pain off and on since then, with some unspecified knee pain and testicular pain.

In the most recent examination of 9/6/06, he was seen by Dr. Edmondsen, with barely legible medical documentation as appeared customary for this and the rest of the 2005-2006 records. Records from 2003-2004 were typed but failed to provide medication documentation to support the drug therapies prescribed.

C. DISPUTED SERVICES:
Prescriptions for hydromorphone, hydrocodone, fentanyl, duragesic from December 14, 2004 through October 9, 2005 denied for coverage as not being medically necessary.

D. DECISION:
I **AGREE** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:
There is no legible or logical medical documentation to support the drug therapies administered.

F. SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED:
Careful review of the medical documentation provided.