



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: () Health Care Provider (X) Injured Employee () Insurance Carrier

Requestors Name and Address:

MDR Tracking No.: M5-06-2152-01 (current MDR#)
M4-06-6687-01 (former MDR#)

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
Facility Insurance Corporation
Rep Box # 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: The Requestor did not submit a Position Summary to MDR.

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. Receipts for office visits and prescription medications

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "This dispute concerns a claimant's request for reimbursement for payments made between February 22, 2006 and June 14, 2006. The carrier submits that this dispute should be dismissed for the reasons provided above. The carrier has not been given an adequate opportunity to review the claimant's request and take final action on said request. If the claimant submits a proper request to the carrier, the carrier will review the request and make a determination at that time."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-22-06 to 06-14-06	Office visits and prescriptions	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION FINDINGS AND 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:

10-06-06

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.

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

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-2152-01
Name of Patient:	
Name of URA/Payer:	Facility Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Edward Sleight, MD

September 26, 2006

An independent review of the above-referenced case has been completed by a physician board certified in family practice. 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

DOCUMENTS REVIEWED

1. Letter dated 9/11/06 from Rhett Robinson, lawyer
2. Review letters from Dr. Brenman dated 8/29/05 and 9/30/05
3. Office notes from Dr. Sleight from 3/13/03 through 8/17/06
4. MRI report on C-spine dated 12/17/03
5. MRI report on C-spine dated 2/21/01

CLINICAL HISTORY

Mr. ___ suffered a work related injury on ___. He underwent extensive evaluation and treatment for over a decade. His treatments included multiple medications, physical therapy, and cervical epidural steroid injections. According to the enclosed records he has been on a hydrocodone based medication and benzodiazepines for at least three years.

REQUESTED SERVICE(S)

Office visits and prescription medications (Temazepam and Hydrocodone/APAP)

DECISION

Denied

RATIONALE/BASIS FOR DECISION

Unfortunately, Mr. ___ has failed a long and exhaustive treatment regimen and is classified as a chronic pain patient. However, the requested medications are not medically necessary or appropriate for this patient. No records submitted reflect the patient received other medications for chronic pain including tricyclics, non-narcotic pain medications, NSAIDS, Cox 2 inhibitors, and pain blockers like Neurontin, Topamax, etc. No documentation was noted of any attempt to taper his current medications or any participation in a chronic pain management program. Long-term maintenance therapy with narcotics and benzodiazepines is not recommended or supported by current data and guidelines because of the significant potential for tolerance, dependence, addiction, side effects, and toxicities. This viewpoint is supported by the current literature, textbooks, and generally accepted guidelines on chronic pain including ACOEM and CMS. Therefore the requested medications are not authorized.

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