



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: () Health Care Provider (X) Injured Employee () Insurance Carrier	
Requestor's Name and Address: C/O McLeaish & Associates, P.C. P O BOX 381609 Duncanville, Texas 75138	MDR Tracking No.: M5-07-0212-01 (current MDR #) M4-06-7876-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: National American Insurance Company Rep Box # 02	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "Enclosed please find a copy of the letter sent to Ms. Lisa McGregor, adjuster for National American Insurance, dated May 3, 2006, and requesting reimbursement for medications that were medically necessary for our client's injury. However, as of this date, the Carrier had not responded to our request."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. Receipts for out of pocket expenses (prescription medications)
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "The issue for this position centers on whether or not the medications of narcotics and muscle relaxants are reasonable and necessary, and whether a home program and over-the-counter anti-inflammatories are appropriate for care..."

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)
08-31-05, 09-27-05 and 10-20-05	Carisoprodol (\$35.99 X 3 dates of service)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$107.97
12-02-05	Cyclobenzaprine	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$12.39
08-31-05, 09-27-05, 10-20-05 and 01-20-06	Hydrocodone/APAP (\$55.59 X 4 dates of service)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$222.36
11-16-05, 12-08-05 and 12-26-05	Hydrocodone/APAP (\$72.59 X 3 dates of service)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$217.77
TOTAL DUE			\$560.49

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 dispute was received by Medical Dispute Resolution on 08-14-06. Dates of service 06-04-05 and 08-01-05 were untimely filed per Rule 133.308(e)(1) which states "A request for retrospective necessity dispute resolution of a medical bill... shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute." These dates will therefore not be a part of the review.

The Requestor withdrew dates of service 07-14-05, 07-29-05 and 08-18-05, therefore these services will not be a part of the review.

Reimbursement for out of pocket expenses of \$560.49 is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.503
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 \$560.49. 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.

Findings and Order by:

03-07-07

Authorized Signature

Typed Name

Date of Findings and 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.

Notice of independent Review Decision

Amended January 24, 2007

December 7, 2006

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-07-0212-01
CLIENT TRACKING NUMBER: M5-07-0212-01/5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above-mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing 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.

Records Received:

Records received from the state:
Notification of IRO Assignment – 1 page
IRO Assignment Letter – 1 page
Medical Dispute Resolution Request/Response – 2 pages
Provider List – 1 page
Table of Disputed Services – 2 pages
Explanation of Review – 2 pages

Records received from the provider:

Request for Production of Documents 11/7/06 – 1 page
Follow-up pain management visit notes 12/4/03, 1/8/04, 2/11/04, 2/25/04, 3/24/04, 4/19/04, 4/21/04, 6/17/04, 7/15/04, 8/18/04, 9/15/04, 10/14/04, 11/3/04, 12/1/04, 3/2/05, 5/26/05, 6/23/05, 7/21/05, 8/25/05, 10/27/05, 1/20/06, 4/24/06 – 35 pages
Patient Questionnaires/Patient Comfort Assessment Guides – 47 pages
Anesthesia Record 3/24/04, 6/23/05 – 2 pages
Report of MRI of the lumbar spine 4/26/06 – 1 page
Neurosurgical follow-up 5/16/05 – 1 page
Review of records 10/5/05 – 7 pages
Letter from Ed Cerday, MD 12/1/05 – 1 page
Mental Health Evaluation 4/4/06 – 4 pages

Records received from the respondent:

Explanation of Review – 2 pages

Reviews 10/5/05, 10/17/06 – 9 pages

Summary of Treatment/Case History:

The claimant is a 50 year old lady who allegedly suffered a workplace injury on _____. Subsequently she developed low back pain with radiation to the right leg, which is thought to be due to lumbar radiculopathy. Physical examinations reveal positive right SLR intermittently. She has been treated with low-potency opioids, carisoprodol and Elavil, home exercises and at least one epidural steroid injection. Initially she was thought to be a surgical candidate; however, this has apparently been abandoned.

Questions for Review:

Dates of Service 8/31/05 through 1/20/06

1. Services for review: Prescription meds (hydrocodone, carisoprodol, cyclobenzaprine).
2. Please review the cyclobenzaprine on 12/5/05.

Explanation of Findings:

1. Services for review: Prescription meds (hydrocodone, carisoprodol, cyclobenzaprine).

The claimant suffers from chronic low back pain which appears to be due to degenerative disc disease. She apparently is not a surgical candidate and epidural steroid injections have been of minimal benefit. The use of low-dose opioids as well as skeletal muscle relaxants such as carisoprodol is a widely utilized approach to treatment of chronic pain for which no other treatment is effective. (1) Although somewhat controversial, the bulk of the recent literature supports the use of opioids for this indication. (5,6,7) Furthermore, numerous medical society statements are supportive of this treatment. On the basis of this and the lack of success of other treatments, particularly conservative rehabilitative therapy, the use of the current medications should be considered to be medically necessary.

2. Please review the cyclobenzaprine on 12/5/05.

Cyclobenzaprine is another sedative/skeletal muscle relaxant similar in effect to carisoprodol, which can be used alternatively. (2,3) There is no information on why the claimant was changed from carisoprodol to cyclobenzaprine; however, it may have been due to the “bad press” that the former drug has suffered in recent years because of its metabolism to meprobamate, a controlled substance. (4) The use of this medication should be considered medically necessary.

Conclusion/Decision to Certify:

Use of hydrocodone/acetaminophen, carisoprodol and cyclobenzaprine for symptomatic relief of the claimant's low back and leg pain is medically necessary.

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

The use of oral opioids for prolonged periods of time for the treatment of chronic non-cancer pain is specifically within the standard of care as expressed by numerous statements from professional standards-setting bodies. Such use is strictly within the FDA-approved labeling of the single-drug oral opioids. There is no generally accepted upper limit of dose of pure opioid agonists.

References Used in Support of Decision:

1. Hoiriis KT, Pflieger B, McDuffie FC, et al. A randomized clinical trial comparing chiropractic adjustments to muscle relaxants for subacute low back pain. J Manipulative Physiol Ther 2004;27(6): 388–98.
2. Toth PP, Urtis J. Commonly used muscle relaxant therapies for acute low back pain: a review of carisoprodol, cyclobenzaprine hydrochloride, and metaxalone. Clin Ther 2004;26(9): 1355–67.

3. Chou R, Peterson K, Helfand M. Comparative efficacy and safety of skeletal muscle relaxants for spasticity and musculoskeletal conditions: a systematic review. *J Pain Symptom Manage* 2004;28(2): 140-75.
4. Reeves RR, Beddingfield JJ, Mack JE. Carisoprodol withdrawal syndrome. *Pharmacotherapy* 2004;24(12): 1804-6.
5. Rowbotham MC, Twilling L, Davies PS, Reisner L, Taylor K, Mohr D. Oral Opioid Therapy for Chronic Peripheral and Central Neuropathic Pain. *N Engl J Med* 2003;348(13): 1223-1232.
6. Ballantyne JC, Mao J. Opioid Therapy for Chronic Pain. *N Engl J Med* 2003;349(20): 1943-1953.
7. Levy MH. Advancement of opioid analgesia with controlled-release oxycodone. *Eur J Pain* 2001;5 Suppl A: 113-6.
8. Medical Policy for the Use of Controlled Substances for the Treatment of Pain. Federation of State Medical Boards of the United States, Inc., May, 2004. <http://www.fsmb.org/>
9. Wisconsin Medical Society Task Force on Pain Management (2004). Guidelines for the Assessment and Management of Chronic Pain. *Wisconsin Medical Journal* 103: 14-42.
10. Evidence-Based Recommendations for Medical Management of Chronic Non-Malignant Pain: Reference Guide for Clinicians. College of Physicians and Surgeons of Ontario, November, 2000
11. The Use of Opioids for the Treatment of Chronic Pain: A consensus statement from American Academy of Pain Medicine and American Pain Society, 1996, <http://www.ampainsoc.org/advocacy/opioids.htm>

The physician providing this review is board certified in Anesthesiology. The reviewer holds additional certification in Pain Medicine from the American Board of Pain Medicine. The reviewer is a diplomate of the National Board of Medical Examiners. The reviewer has served as a research associate in the department of physics at MIT. The reviewer has received his PhD in Physics from MIT. The reviewer is currently the chief of Anesthesiology at a local hospital and is the co-chairman of Anesthesiology at another area hospital. The reviewer has been in active practice since 1978.

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.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the

medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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Case Analyst: Lori B ext 569