



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: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-07-0707-01 (current MDR #) M5-06-1949-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name: Travelers Indemnity Company Rep Box # 05	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Billed carrier. No response."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. Copies of receipts for out of pocket expenses

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "The enclosed prescriptions are not reasonable and medically necessary for the compensable injury of . Attached are the Required Medical Examination (RME) of July 29, 2004 and the Supplemental Report to the RME dated 10/20/2003."

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)
02-28-05 to 12-30-05	Prescription medications (HC-Ibuprofen, Vicodin, Ambien, Tramadol, Clonazepam, Zoloft, Warfarin, Tizanidine, Fosamax, Nasalcrom, Zithromax, Metranidazole, Oxycodone/APAP, Levaquin, Oxycontin, Percocet and F Ned ointment.)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$00.00
TOTAL DUE			\$00.00

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.

Dates of service 06-05-04 through 01-31-05 were not submitted timely for review per Rule 133.308(e)(1) which states “A request for retrospective necessity dispute resolution of a medical bill pursuant to §133.304, of this title (relating to Medical Payments and Denials), 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.”

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308
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:

05-31-07

Authorized Signature

Medical Dispute Resolution Officer

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:	M5-07-0707-01
Name of Patient:	
Name of URA/Payer:	St. Paul Travelers
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	J. Barton Kendrick, MD

May 29, 2007

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

- Records from Dr. Kendrick
- Records from St. Paul Travelers – Initial Medical Assessment (6/29/00)
- Letter from ____
- Surgical report per Dr. Pevey (8/1/00)
- Lower extremity Doppler report (5/14/04)
- Medical records from Dr. Ponder
- Medical records from Dr. Pevey (7/21/00, 7/19/00)
- CT scan of sacrum/coccyx
- MRI on left knee
- Mental Health Evaluation by Dr. Bettego (6/12/02)
- Designated Doctor's Exam on 7/29/03 by Dr. DeFrancesco
- Medical records from Dr. Cannon
- Addendum DDE by Dr. DeFrancesco (10/20/03)

CLINICAL HISTORY

This patient sustained an injury on _____. She slipped and fell then was diagnosed with contusion of the left buttock. An acute coccyx fracture was ruled out by CT scan. She also had a knee injury and had surgery on her left knee on 8/1/00. She was also treated by medications, rest, trigger point injections, cortisone injections, and a comprehensive pain program was recommended. No records were submitted concerning this program. On 7/22/03, the patient had a MMI assessment and was determined to be at MMI with a 4% impairment rating. This rating was disputed by Dr. Kendrick. CCH on 8/23/06 determined lumbar, cervical, DVT, and chipped tooth were not compensable injuries related to her injury on _____. Depression was ruled compensable.

REQUESTED SERVICE(S)

Ibuprofen, Vicodin, Ambien, Tramadol, Clonazepam, Zoloft, Warfarin, tizanidine, Fosamax, Nasalcrom, Zithromax, Metranidazole, oxycodone/APAP, Levaquin, oxycontin, percocet, F Ned ointment

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This patient had an injury on _____ eventually diagnosed as a buttock contusion and a knee injury. She had extensive treatment including knee surgery August 2000. Depression attributed to her injury was diagnosed and treated. The submitted records do not justify or support the use of any of the requested medications several years after her original injury. There is as paucity of records after 2003 and no records to support extraordinary circumstances to justify these prescriptions. This view point is supported by ACOEM guidelines and ODE guidelines.

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, 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.

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