THIS MDR TRACKING NO. WAS WITHDRAWN.
THE AMENDED MDR TRACKING NO. IS: M5-04-1446-01

MDR Tracking Number: M5-03-1942-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4-1-03.

The IRO reviewed prescription medication rendered from 5-20-02 through 7-19-02 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

The IRO concluded that Furosemide, Carisoprodol and Potassium Chloride were not medically necessary. The IRO concluded that Amitriptyline, Neurontin and Fluoxatine were medically necessary.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 3, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

Neither party submitted EOBs to support services identified as "No EOB"; therefore, they will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-19-02	Oxycontin 80 mg #180	$1637.65	$0.00	No EOB	$1622.81	Pharmacy Fee Guideline (II)(D)	The provider did not submit any report to support delivery of service that Oxycontin cured and relieved the effects naturally resulting from compensable injury; therefore, no reimbursement is recommended.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 5-20-02 through 7-19-02 in this dispute.

This Decision and Order is hereby issued this 30th day of December 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

September 2, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

Patient:
TWCC #:
MDR Tracking #: M5-03-1942-01
IRO #: 5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the care rendered 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy board certified in anesthesiology and specialized in pain management. The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ sustained work related injuries (DOI ___) to the upper extremities. Her diagnosis was apparently listed as bilateral entrapment neuropathy. Multiple nerve decompression surgeries to the upper extremities were performed with no apparent benefit. It seems that at some point she developed Reflex Sympathetic Dystrophy of the upper extremities. Medical management for that condition has been in place for an extended period.

DISPUTED SERVICES

Under dispute is the medical necessity of

DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The Ziroc reviewer agrees with the findings regarding medications Furosemide, Carisoprodol and Potassium Chloride, finding them to be medically unnecessary.

Medications found to be of necessity include Amitriptyline, Neurontin and Fluoxatine.

BASIS FOR THE DECISION

Furosemide, Carisoprodol and Potassium Chloride are generally not considered to be necessary in the treatment of Reflex Sympathetic Dystrophy. Medications of necessity include p.o. analgesics which does incorporate Hydrocodone Acetaminophen preparations, Tri-Cyclic anti-depressants, neuro-modulatory drugs and seratonin reuptake inhibitors. Those medications represented by those classes used herein, are Amitriptyline, Neurontin and Fluoxatine.

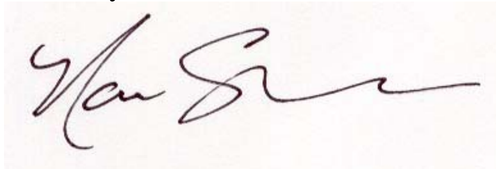
Reflex Sympathetic or Complex Regional Pain Syndrome Type I remains a very difficult area in pain medicine with regard to accurate diagnosis and effective treatment. It does appear to be widely agreed that one of the mainstays of therapy includes diligent regular, vigorous, physical therapy to the affected extremities. Beyond that, sympathetic mediation with specific blocks do have their place in this disorder. Medical management, usually directed at the pain component, is agreed to be reasonable and quite usually necessary. The reviewer has not seen indication in the materials provided that suggest that this patient is currently involved or has been involved in on-going physical therapy. While the reviewer can agree with the use of Hydrocodone Acetaminophen preparations, specifically Elavil, Neurontin & Prozac, and to a lesser degree Prevacid, he has not been able to substantiate that diuretic therapy with its need for Potassium supplementation is a reasonable approach in dealing with edema associated with Complex Regional Pain Syndrome Type I.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding this finding by US Postal Service to the TWCC.

Sincerely,



Nan Cunningham
President/CEO

CC: Ziroc Medical Director