

MDR Tracking Number: M5-03-0395-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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.

The IRO determined that a portion of the disputed medications were medically necessary. The amount due for the medications found medically necessary exceeded the sum of those medications found not medically necessary. Therefore, the Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. The requestor was also the injured worker in this dispute, therefore, in accordance with §133.308(q)(9), no reimbursement of the IRO fee is due the respondent. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The disputed Neurontin, Prozac and Vicodin prescribed on 9/25/01 were medically necessary. The disputed prescription medications prescribed on 5/8/01 and 7/22/01 were found to not be medically necessary. The respondent raised no other reasons for denying reimbursement.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to date of service 5/8/01 through 9/25/01.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 18th day of February 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

February 3, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0395-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in physical medicine and rehabilitation. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 55 year-old gentleman who sustained a work related injury on ___. The patient reports that while working on ___ he was moving a mobile home along the line of construction when he felt a popping sensation in his neck and left shoulder. The patient had previously sustained an injury to his neck and shoulder and underwent C6-C7 anterior discectomy and fusion on 12/18/97. The patient has had numerous X-Rays, MRI of the left shoulder and neck area, CT scan, cervical myelogram, EMG/NCV, and FCE. The patient has been treated with surgery, physical therapy, multiple medications and TENS.

Requested Services

Prescriptions denied on 5/8/01, 7/22/01, and 9/25/01.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

___ physician reviewer indicated that the patient sustained a work related injury on ___. ___ physician reviewer also indicated that the injury of ___ is causally related to exacerbation of present pain issues. ___ physician reviewer explained that anticonvulsants and narcotics do

have a role in managing patients with chronic pain. (Richard S. Weiner: Pain Management; A Practical Guide for Clinicians. Vol. 1&2: 1998). ___ physician reviewer also explained that antidepressants also have a role in pain management. (P. Pirithri Raj: Practical Management of Pain; 3rd Edition. 2000). Therefore, ___ physician consultant concluded that the Neurontin, Prozac, and Vicodin prescribed on 9/25/01 were medically necessary to treat this patient's condition. However, the medications prescribed on 5/8/01 and 7/22/01 were not medically necessary to treat this patient's condition.

Sincerely,

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