MDR Tracking Number: M5-03-0711-01

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 Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. 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 prescribed medications, Biofreeze, Trazadone, Ultram, Chloraxazone, Medrol, Neurontin and Effexor-XR were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these prescribed medication charges.

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 dates of service 6/5/01 through 8/23/01 in this dispute.

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 27th day of February 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

December 30, 2002

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-0711-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to __ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 28 year old female sustained a work-related injury on ___ when she injured her lower back. The patient underwent a L4-5 posterio-lateral lumbar interbody fusion with cages and is now experiencing lumbar radiculopathy with severe spasm. In an effort to relieve the patient's symptoms, the treating physician has prescribed Biofreeze, Trazadone, Ultram, Chloraxazone, Medrol, Neurontin, and Effexor-XR.

Requested Service(s)

Biofreeze, Trazadone, Ultram, Chloraxazone, Medrol, Neurontin, and Effexor-XR, prescribed from 06/05/01 through 08/23/01.

Decision

It is determined that the Biofreeze, Trazadone, Ultram, Chloraxazone, Medrol, Neurontin, and Effexor-XR, prescribed from 06/05/01 through 08/23/01 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that this patient is suffering from chronic pain syndrome that requires appropriate management and some modalities of treatment. It is standard medical practice to make every effort to improve pain control and minimize the side effects of essential therapies. The use of the prescribed medications is essential in order to manage the patient's pain and maintain and/or improve her quality of life. Therefore, the Biofreeze, Trazadone, Ultram, Chloraxazone, Medrol, Neurontin, and Effexor-XR, prescribed from 06/05/01 through 08/23/01 were medically indicated.

Sincerely,