

MDR Tracking Number: M5-03-1057-01

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 (Celebrex, Carisoprodol, and Hydrocodone/Acetaminophen) were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for prescribed medications (Celebrex, Carisoprodol, and Hydrocodone/Acetaminophen) 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 2/13/02 through 5/8/02 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 9<sup>th</sup> day May 2003.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqp

NOTICE OF INDEPENDENT REVIEW DECISION

March 27, 2003

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

RE: MDR Tracking #: M5-03-1057-01  
IRO Certificate #: IRO 4326

The \_\_\_ 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 patient sustained a work-related injury on \_\_\_ when he suffered spinal injuries from lifting manhole covers. The patient is status post anterior cervical decompression and fusion of C5-6. He continues to complain of residual neck pain and right cervical radiculopathy. The treating physician prescribed Celebrex, carisoprodol, and hydrocodone/acetaminophen for his symptoms.

### Requested Service(s)

Celebrex, Carisoprodol, and Hydrocodone/Acetaminophen prescribed from 02/13/02 through 05/08/02.

### Decision

It is determined that the Celebrex, carisoprodol, and hydrocodone/acetaminophen prescribed from 02/13/02 through 05/08/02 were medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

It is within acceptable medical practice to utilize non-steroidal anti-inflammatory drugs (NSAIDs), muscle relaxants and oral narcotics intermittently over the short, medium, or long term in the treatment of patients with spinal disc conditions that were treated surgically or otherwise. Although there is no indication from the medical record documentation as to the amount or frequency that the patient was actually taking the medications, the individual quantities listed in the pharmacy prescriptions was appropriate for the patient's symptoms. Therefore, the Celebrex, carisoprodol, and hydrocodone/acetaminophen prescribed from 02/13/02 through 05/08/02 were medically necessary.

Sincerely,