THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-4082.M5

MDR Tracking Number: M5-03-1745-01

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 prescription medications were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these prescription 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 4/12/02 through 6/7/02 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 13th day of June 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

June 11, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1745-01

___ 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 the ___ external review panel. This physician is board certified in internal medicine. The ___ 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, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a gentleman who sustained a work related injury on ___. This injury is reported to be a repetitive stress injury and compressive anular torsion secondary to operation of a jackhammer. The diagnoses for this patient included lumbosacral radiculopathy, cervical radiculopathy and marked secondary myofascial pain. The patient is currently under the care of pain management and being treated with oral medications.

Requested Services
Prescriptions from 4/12/02 through 6/7/02.

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

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 47 year-old male who sustained a work related injury on ___. The ___ physician reviewer also noted that the patient sustained a repetitive stress injury and compressive anular torsion secondary to operation of a jackhammer. The ___ physician reviewer indicated that this patient has been under the care of pain management specialist for the treatment of lumbosacral radiculopathy, cervical radiculopathy, and myofascial pain. The ___ physician reviewer noted that the patient is currently on a regimen of oral medications that include Methadone, Zoloft, Zanaflex and Provigil. The ___ physician reviewer indicated that this patient has a chronic pain syndrome that is currently managed with oral medical therapy. The ___ physician reviewer explained that the rationale for the present medical regimen is consistent with acceptable standards of medical practice for

the treatment of a chronic pain syndrome. The ___ physician reviewer also explained that interventional therapy for the treatment of this patient's condition is not an option at this time. The ___ physician reviewer further explained that this patient's injuries and ensuing diagnoses are essentially not able to be resolved and will require long-term medical therapy. Therefore the ___ physician consultant concluded that the prescriptions from 4/12/02 through 6/7/02 were medically necessary to treat this patient's condition.

Sincerely,