MDR Tracking Number: M5-03-2284-01

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.

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, Bextra and Topamax were found to be medically necessary. The medications, Propoxyn and Baclofen were not 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 2/8/03 through 3/18/03 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 25th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

July 22, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2284-01

An independent review of the above-referenced case has been completed by a medical physician [board certified] in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
All available records were thoroughly reviewed. ___ has a very special lengthy and complicated history. In summary, she has bilateral carpal tunnel releases in 1993 along with bilateral elbow surgery to release ulnar nerve entrapments with a subsequent surgery on her left elbow. Her symptoms apparently resolved within a few years, then symptoms abruptly recurred on May 27, 2000. There was no precipitating factor or trauma to cause her symptoms. Apparently, this condition was considered a worker's compensation injury, although no worker's compensation reports are included in her records.

After failing conservative therapy, she had bilateral ulnar nerve releases performed in 2001. (She had subsequent shoulder surgery, which appears unrelated to her worker's compensation injury). She continued to have symptoms and a variety of doctor's, medications, and physical therapy was employed with only moderate success.

REQUESTED SERVICE (S)
Bextra, propoxyn, baclofen, and topamax were requested medications.

DECISION

Uphold denial for propoxyn and baclofen. Overturn denial and recommend approving bextra and topamax.

RATIONALE/BASIS FOR DECISION

___ has developed a chronic pain syndrome. Although RSD is mentioned, their diagnosis is not supported in the clinical data. Propoxyn and Baclofen are not acceptable standards of care or FDA approved for long term chronic pain syndromes. Bextra and Topamax are routinely used for chronic pain syndromes and have proven to give this patient some relief from her symptoms.