MDR Tracking Number: M5-03-2595-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on 6-17-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. 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 for Ibuprofen was found to be medically necessary. The prescriptions for Hydrocodone/APAP and duragesic patches were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 1-14-03 through 4-4-03 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 19th day of December 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

August 1, 2003

MDR Tracking Number: M5-03-2595-01
IRO Certificate# 5259

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 clinical information available was thoroughly reviewed. ___ incurred a work related back injury on ___. The initial treatment note is from ___ on 12/9/96 which appears to be a follow-up visit, and he recommended light duty, Cataflam and Ultram. ___recommended surgery and an L5-S1 fusion with bone graft fixation was performed on 6/4/97 by ___. MMI was done on 6/4/97 by ___ who assessed a 14% whole body impairment rating and ___ apparently agreed to this rating. Apparently the accuracy of this rating is in dispute. Because of persistent pain, ___ removed the hardware on 9/15/99, but the patient had a subsequent increase in pain. An imaging study on 3/9/00 showed no postoperative abnormality and no compression of any neural elements at any site. Subsequently, ___ saw multiple physicians for pain management treatments that included medications, physical therapy, and a trial with a spinal cord stimulator.

REQUESTED SERVICE (S)
Medications requested were hydrocodone/APAP, Duragesic patches and Ibuprofen.

DECISION
Approve Ibuprofen. Uphold denial for hydrocodone and Duragesic.

RATIONALE/BASIS FOR DECISION
The clinical records indicate ___ had a chronic pain syndrome or 'post laminectomy syndrome' after his lumbar fusion. After failing an appropriate course of conservative treatment, other etiologies should be investigated including psychosocial, situational, and motivational issues especially since this patient's subjective symptoms are out of

proportion to any physical or objective findings. Ibuprofen is an appropriate and accepted treatment option for most chronic pain situations with the appropriate monitoring for known side effects. Scheduled, regular doses of narcotics such as hydrocodone and Duragesic are not appropriate for long term pain control for this patient. These medications are typically indicated for acute break through pain uncontrolled with lesser medications or terminal pain situations (e.g. cancer) unresponsive to non-narcotic medications and other modalities for pain control. These narcotic medications have significant side effects including the risk of developing tolerance, dependence, and addiction. Also in this case, ___ only had moderate pain relief (maximum of 40% is documented) with these powerful medications. Finally, no records are noted for a comprehensive pain management program assessment including a thorough psychological evaluation nor are there records showing any electrodiagnostic testing was done to try to further delineate the etiology of ___ continued, severe pain syndrome.