

MDR Tracking Number: M5-03-2701-01

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 6-24-03.

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(r)(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 hydrocodone with APAP, carisoprodol (Soma), and Ambien from 6-28-02 through 10-7-02 were 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 6-28-02 through 10-7-02 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 11th day of September 2003.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

DZT/dzt

#### NOTICE OF INDEPENDENT REVIEW DECISION

September 4, 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 # M5-03-2701-01  
IRO Certificate # IRO4326

\_\_\_ 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 orthopedic surgery 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 \_\_\_, resulting in a medial meniscal tear. He underwent a right knee arthroscopy for a medial meniscectomy, date unknown.

#### Requested Service(s)

Hydrocodone with APAP, carisoprodol (Soma), and Ambien from 06/28/02 through 10/07/02

#### Decision

It is determined that the hydrocodone with APAP, carisoprodol (Soma), and Ambien from 06/28/02 through 10/07/02 were medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

The drugs as prescribed are not beyond what would be considered appropriate in certain circumstances following this type of surgery. The amounts of the drugs prescribed were more than one would ordinarily expect; however, certain circumstances would allow for a greater number, especially when ordered "as needed". The dosages and time intervals as ordered were appropriate to treat this patient. Therefore, it is determined that the hydrocodone with APAP, carisoprodol (Soma), and Ambien from 06/28/02 through 10/07/02 were medically necessary.

Sincerely,