

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

**SOAH DOCKET NO. 453-04-2736.M5**

MDR Tracking Number: M5-03-2733-01

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. This dispute was received on June 5, 2003.

The IRO reviewed prescribed medications: Prevacid, Hydrocodone/APAP, Carisoprodol rendered on 6/5/02 through 7/2/02 denied based upon "V".

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 not the only issue** to be resolved. The Prevacid, Hydrocodone/APAP, Carisoprodol rendered on 6/5/02 through 7/2/02 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 11, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	DRUG	Billed	Paid	EOB Denial Code	Reference	Rationale
2/4/03	Hydro/Apap 10/500 mg #40	\$32.64	\$0.00	R	TWCC Rule 134.502(f) & 134.503 (a-e)	Review of the Commission's records revealed that a TWCC 21 was not filed disputing extent or compensability, therefore the date of service in dispute will be reviewed according to the <u>PFG</u> . The requester submitted documentation to support delivery of service. Therefore the requester is entitled to reimbursement of the prescribed medication.
2/4/03	Carisoprodol 350 mg #40	\$141.06	\$0.00	R		
TOTAL		\$173.70	\$0.00			The requestor is entitled to reimbursement in the amount of \$173.70

### ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision and Order is applicable for dates of service 6/5/02 through 2/4/03 in this dispute.

This Order is hereby issued this 19<sup>th</sup> day of January 2004.

Margaret Q. Ojeda  
 Medical Dispute Resolution Officer  
 Medical Review Division  
 MQO/mqo

August 15, 2003

MDR Tracking Number: M5-03-2733-01  
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

Medical records were thoroughly reviewed which included a review letter by \_\_\_ and clinical notes from \_\_\_\_. This patient sustained a work related back injury on \_\_\_\_. He was treated by \_\_\_ with chiropractic care and physical therapy. A lumbar MRI in 11/91 revealed degenerative changes with no herniation and the patient entered a work hardening program. (Unfortunately, no notes concerning this program were available.) Apparently, his pain persisted and he had a normal bone scan and CT of his lumbar spine. MMI was determined on 11/4/92 as 7% disability for whole person. Eventually, a lumbar discogram on 12/22/92 revealed an annular tear and an epidural steroid injection was done on 1/15/93 with no improvement. The next notation is not until 12/10/97 when the patient saw \_\_\_ in follow-up and has a normal exam with some paraspinal muscle tenderness. On 3/4/99, \_\_\_ felt the patient had reached MMI but no DI rating was noted. The last note was from \_\_\_ on 3/1/03 for follow-up from a MVA.

#### REQUESTED SERVICE (S)

Requested services were for Prevacid, hydrocodone/APAP, Carisoprodol from dates 6/5/02-7/2/02.

## DECISION

Reverse the previous denial and approve the above medications.

## RATIONALE/BASIS FOR DECISION

According to the available medical records, this patient had no prior back symptoms prior to his work related injury on \_\_\_\_\_. Although a MRI revealed degenerative changes (which are chronic), a discogram showed an annular tear, which appears to be the pain generator. This tear appears to be as a result of his work related injury, as he had no pain or back symptoms prior to that incident. Although these medications would not normally be used for chronic pain, this patient was not conclusively diagnosed until after the disputed dates. Therefore, since the patient was still in the active treatment phase from his injury and he had relief with these medications, they should be approved for the above mentioned dates.