MDR Tracking Number: M5-03-2834-01

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 (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 July 7, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Norgesic and Ketoprofen cream were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment Norgesic and Ketoprofen were not found to be medically necessary, reimbursement for date of service 4/3/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of September 2003.

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

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-2834-01

September 8, 2003

An independent review of the above-referenced case has been completed by a doctor 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
This patient sustained a work related injury on ___. Initially, he was treated conservatively by ___ although no records are noted for review. Subsequently, he was treated by ___ conservatively with surgery recommended for his shoulder on 12/5/97. The patient had surgery on 4/6/00 with subsequent post-operative treatment including extensive PT and medications.

REQUESTED SERVICE(S)
Medical necessity of prescriptions on 4/2/02. (Note: receipts were dated 4/2/03 for Norgesic and Ketoprofen cream.)

DECISION
Uphold prior denial.

RATIONALE/BASIS FOR DECISION
All submitted records were thoroughly reviewed. After the patient's operative procedure on 4/6/00, he was treated with PT and various medications. As of 10/24/00, he was referred to TRC for 'sedentary light type work". Subsequent treatments appear to consist of primarily medications and a HEP. Patient was to return to clinic on an as necessary basis. It appears the patient reached his MMI approximately 6 months after his surgery. No documentation is noted for a MMI evaluation, a pain specialist referral, or work hardening program. Therefore, his symptoms appear mild and not severe enough to continue to require prescription medications on 4/2/03.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of

Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 11th day of September 2003.