

MDR Tracking Number: M5-03-2879-01

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 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 prescribed medication: Nexium was found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the prescribed medication: Nexium.

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 7/17/02 through 8/16/02 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 18<sup>th</sup> day of September 2003.

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

September 17, 2003

**NOTICE OF INDEPENDENT REVIEW DECISION**  
**Corrected Letter**

**RE: MDR Tracking #: M5-03-2879-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in orthopedic surgery. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a male who sustained a work related injury on \_\_\_. The patient has been diagnosed with disc herniation at the L4-L5 level with stenosis. The patient is being treated with oral medications that include Nexium.

#### Requested Services

Prescriptions from 7/17/02 through 8/16/02.

#### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

#### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a male who sustained a work related injury. The \_\_\_ physician reviewer indicated that the treating physician's letter of 10/21/02 describes the rationale for prescribing Nexium. The \_\_\_ physician reviewer explained that the physician established the medical necessity of using a gastric acid reducing agent in this patient's case. The \_\_\_ physician reviewer indicated that the patient's L4-L5 disc herniation necessitated pain medication. The \_\_\_ physician reviewer explained that the Nexium increased the patient's tolerance of the pain medication. Therefore, the \_\_\_ physician consultant concluded that the prescriptions from 7/17/02 through 8/16/02 were medically necessary to treat this patient's condition.

Sincerely,