

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee.

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 medications were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the medications.

The above Findings and Decision are hereby issued this 4<sup>th</sup> day of August 2002.

Dee Z. Torres, Medical Dispute Resolution Officer  
Medical Review Division

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 9-18-01 through 11-19-01 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 4<sup>th</sup> day of August 2002.

Roy Lewis, Supervisor, Medical Dispute Resolution  
Medical Review Division

RL/dzt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

July 11, 2002

Texas Workers' Compensation Commission  
Attention: Rosalinda Lopez, Case Manager  
Medical Dispute Resolution  
4000 South IH-35, MS 48  
Austin, TX 78704-7491

Re: Medical Dispute Resolution  
MDR #: M5-02-2248-01  
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Anesthesia/Pain Management.

THE REVIEWER OF THIS CASE **DISAGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER. **The medications given are medically necessary.**

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

## MEDICAL CASE REVIEW

This is for \_\_\_\_\_. I have reviewed the medical information forwarded to me concerning TWCC Case File #M5-02-2248-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of prescribed pain medicines.
2. Correspondence.

B. BRIEF CLINICAL HISTORY:

The patient was apparently injured at work on \_\_\_\_\_ and has back pain, and is being prescribed pain medications for the treatment of her back pain. These medications have been denied as being unnecessary.

In the carrier's denial, it was indicated that the medication required a letter of medical necessity. I am in possession of a letter of medical necessity by Alternative Pain and Injury Clinic stating that the Darvocet is for pain, the Skelaxin is to decrease and control muscle spasms, and the Neurontin is to decrease neuropathic pain, and the Naprelan is being used as an anti-inflammatory.

C. DECISION:

THE TREATMENT DELIVERED IN THIS CASE IS MEDICALLY NECESSARY. I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER.

The medications in this case are medically necessary, and this would put me in disagreement from the previous review. While these medications are not exactly what I might choose in the treatment of lower back pain in a patient like this, they are indeed within the standard of medical care and are indeed medically necessary in this case.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

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Date: 7 July 2002