

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. 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 prescriptions from 9-24-01 through 11-13-01 were found to be medically necessary. The prescription for 9-11-01 with no denial reason given was not supported or documented per the 1996 Medical Fee Guideline in that the requestor did not submit a prescription for the medication to include claimant's diagnosis, prognosis, and expected duration of the medication. Therefore, no reimbursement is recommended for the prescription on 9-11-01. The requestor submitted a letter stating that the insurance carrier paid all other prescriptions from 8-23-01 through 12-13-01 that had no denial reason on the EOB. The respondent raised no other reasons for denying reimbursement for these services charges.

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 8-23-01 through 12-13-01 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 21st day of May 2003.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

DZT/dzt

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** January 27, 2003

**Requester/ Respondent Address :** Rosalinda Lopez  
TWCC  
4000 South IH-35, MS-48  
Austin, Texas 78704-7491

**RE: MDR Tracking #:** M5-02-3266-01  
**IRO Certificate #:** 5242

\_\_\_ 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 Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed 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 Physical Medicine and Rehabilitation physician reviewer who is board certified in Physical Medicine and Rehabilitation. The Physical Medicine and Rehabilitation 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**

Review of the available medical information indicates that the dispute revolves around the medical necessity of medications from 9/24/01 through 11/13/01. According to the table of disputed services, it is indicated that the medication of Effexor, Lortab and Neurontin were reportedly considered to be medically unnecessary based on a peer review.

There is an additional indication of a denial on 11/13/01 for Lortab that is indicated to have been denied per the adjuster as not longer needed reasonable and necessary.

### **Requested Service(s)**

The medical necessity of medications (Effexor, Lortab and Neurontin) from 9/24/01 through 11/13/01.

## **Decision**

I am in agreement with the provider who requested the prescription medication and disagree with the insurance carrier.

## **Rationale/Basis for Decision**

The primary basis for the denial of the medications noted above was indicated to have been based on a peer review by the insurance carrier. The submitted medical information did not include any peer review or other medical information indicating what the considerations were for denial of the medication during the time period of 9/24/01 and 11/13/01. There are indications within the information received that there was no denial on the same medications for 8/23/01, 9/11/01, 11/13/01 for Effexor and Neurontin, nor for the medications on 12/13/01.

The patient's treating doctor, \_\_\_\_, board certified in physical medicine and rehabilitation, on 2/25/02 wrote a letter indicating that the patient had sustained an injury in the lower back with pain radiating into the left lower extremity. The pain was exacerbated by increased activities in the described areas as well as with frequent bending and squatting.

The examination had indicated a painful range of motion. There was also tenderness noted upon palpation of the lumbosacral spinous processes, the bilateral paraspinal muscles, the left gluteal muscles, the left sacroiliac joint, and the left sciatic notch. She experienced numbness and tingling into the left lower extremity as well as decrease in strength. X-ray findings indicated degenerative changes. The patient had MRI performed of the lumbar spine, which illustrated a bulging disc at L4/5 and L5/S1. EMG studies indicated evidence of a left S1 neuropathy. Examination also showed evidence of possible piriformis syndrome. Examination of the lower extremities demonstrated tenderness and muscle spasm. She also experienced depression and anxiety. \_\_\_\_ goes on to indicate the rationale for the utilization of the medications which are in question for the dates of 9/24/01 and 11/13/01.

This decision is based on the substantiation of the medical necessity established by the treating doctor and by the isolated indication of medication not being medically necessary during a time period before and after the dates in question along with the fact that there was no peer review provided to substantiate the basis of the decision rendered by the insurance carrier.

This decision by the IRO is deemed to be a TWCC decision and order.

<p>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 requester and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 28th day of January 2003.</p>
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