MAXIMUS

August 27, 2003

Texas Workers Compensation Commission
Southfield Building, MS48
4000 S. IH-35
Austin, Texas 78704-7491

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2672-01
TWCC #:
Injured Employee:
Requestor: VONO
Respondent: Asso. Casualty
MAXIMUS Case #: TW03-0394

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS external review panel. This physician is board certified by the osteopathic board of internal medicine. The MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on . The patient reported that while at work she slipped and almost fell. The patient reported that she injured the left side of her body, including her low back and leg. The diagnoses for this patient included internal derangement of her left knee, lumbar radiculopathy, chronic pain in her low back, left knee and ankle. The patient has been treated with oral pain medications.

Requested Services

Prescriptions from 6/21/02 through 8/27/02.

Decision

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

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her low back and leg on . The MAXIMUS physician reviewer also noted that the diagnoses for this patient include internal derangement of the left knee, lumbar radiculopathy and chronic pain in her low back, left knee and left ankle. The MAXIMUS physician reviewer further noted that treatment for this patient's condition has included oral pain medications. The MAXIMUS physician reviewer indicated that the medical documentation in the case file contained only a letter of medical necessity written by the treating physician. However, the MAXIMUS physician reviewer explained that the treatment of the patient's condition with Ibuprofen and Hydrocodone with APAP is supported. The MAXIMUS physician reviewer indicated that the patient was prescribed Promethazine. The MAXIMUS physician reviewer explained that Promethazine, an anti-nauseant, is not routinely prescribed for treatment of this patient's condition. The MAXIMUS physician reviewer also explained that the medical documentation provided does not support the medical necessity of Promethazine for treatment of this patient's condition. Therefore, the MAXIMUS physician consultant concluded that the Ibuprofen and Hydrocodone with APAP prescribed from 6/21/02 through 8/27/02 were medically necessary to treat this patient's condition. However, the MAXIMUS physician consultant also concluded that the Promethazine prescribed from 6/21/02 through 8/27/02 was not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department