

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-2055.M5

MDR Tracking Number: M5-04-0318-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-2-03.

The Medical Review 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 prescriptions for Diazepam, Hydrocodone, Vicodin ES, and Valium 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 Medical Review Division has determined that medical necessity were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 10-14-02 through 1-21-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 4th day of December 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

December 3, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-0318-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- 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 by the American Board of Osteopathic Internal Medicine. 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 female who sustained a work related injury on ----- . The patient reported that while at work she injured her right shoulder/arm and cervical spine while lifting a patient. An MRI dated 12/5/94 showed derangement of the distal supraspinatus tendon with swelling and diffuse tendon maceration and small tears could not be ruled out. An EMG dated 12/22/94 showed right carpal tunnel syndrome, right wrist carpal tunnel syndrome and left carpal tunnel syndrome without evidence of radiculopathy. The patient was treated with injections, physical therapy and oral medications. An MRI of the cervical spine dated 3/19/03 showed 3-4mm disc bulge at C6-7, 2mm disc bulge at C5-6, 2-3mm disc bulge at C3-4 and mild degenerative hypertrophic cervical spondylosis at C2-3, C3-4, C4-5, C5-6 and C6-7. Recent diagnoses for this patient have included chronic mechanical cervicothoracic pain/strain syndrome, right upper extremity peripheral neuropathy, chronic mechanical right shoulder/arm pain and chronic anxiety associated with pain. Current treatment of this patient has included Diazepam and Vicodin ES.

Requested Services

Diazepam, Hydrocodone, Vicodin ES and Valium from 10/14/02 through 1/21/03.

Decision

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

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a female who sustained a work related injury on ----- . The ----- physician reviewer indicated that the patient was started on narcotics and Valium shortly thereafter and has remained on these medications until the present time. The ----- physician reviewer explained that continuing the present medications 8 to 10 years later is not standard of care. The ----- physician reviewer also explained that the long-term use of short acting drugs for pain control is no longer standard of care. The ----- physician reviewer indicated that the documentation provided did not show that the patient has been

referred to a pain specialist for conversion to long acting drugs for a more definitive treatment course. Therefore, the ----- physician consultant concluded that the Diazepam, Hydrocodone, Vicodin ES and Valium from 10/14/02 through 1/21/03 were not medically necessary to treat this patient's condition.

Sincerely,