

MDR Tracking Number: M5-04-0712-01

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, 133.307 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. This dispute was received on 11-05-03.

The IRO reviewed prescriptions for Celebrex, Carisoprodol, Hydro-APAP, Promethazine, Topamax and Effexor rendered from 11-06-02 through 11-18-02 that were denied based "V".

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 not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-27-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	NDC CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
11-12-02	00781183001	\$41.50	\$0.00	NO EOB	\$32.70	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of \$32.70
11-27-02	00025152551	\$125.12	\$0.00	R	\$124.02	96 MFG PHARMACEUTICAL GR (I)(B)	R- Compensability accepted by respondent for lumbar spine and left ankle. Services

DOS	NDC CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
							are for lumbar. Reimbursement recommended in the amount of \$124.02

DOS	NDC CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
11-27-02	00045064565	\$195.38	\$0.00	R	\$193.64	96 MFG PHARMACEUTICAL GR (I)(B)	R- Compensability accepted by respondent for lumbar spine and left ankle. Services are for lumbar. Reimbursement recommended in the amount of \$193.64
12-03-02	00008083701	\$163.69	\$0.00	R	\$161.94	96 MFG PHARMACEUTICAL GR (I)(B)	R- Compensability accepted by respondent for lumbar spine and left ankle. Services are for lumbar. Reimbursement recommended in the amount of \$161.94
12-03-02	58809042405	\$209.60	\$0.00	R	\$183.28	96 MFG PHARMACEUTICAL GR (I)(B)	R- Compensability accepted by respondent for lumbar spine and left ankle. Services are for lumbar. Reimbursement recommended in the amount of \$183.28

DOS	NDC CODE	Billed	Paid	EOB Denial Code	MARS	Reference	Rationale
12-16-02	52544038505	\$29.75	\$0.00	R	\$29.75	96 MFG PHARMACEUTICAL GR (I)(B)	R- Compensability accepted by respondent for lumbar spine and left ankle. Services are for lumbar. Reimbursement recommended in the amount of \$29.75
TOTAL		\$765.04	\$0.00				Requestor is entitled to reimbursement in the amount of \$725.33

This Decision is hereby issued this 26th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for dates of service 11-06-02 through 12-16-02 in this dispute.

This Order is hereby issued this 26th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 22, 2004

Re: IRO Case # M5-04-0712

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 40-year-old female who injured her left ankle and right low back in ___ when she slipped and fell. The back pain persisted despite chiropractic care. The patient had a history of a previous back injury which led to a 1997 L5-S1 discectomy and fusion. The patient did well following that fusion, but she continued with some back pain and required facet injections in 1998, about one year after her surgery. The patient was apparently doing well at the time of her ___ injury. A 5/10/01 MRI suggested epidural scarring and facet hypertrophy. The major changes shown in that study and elsewhere were at L4-5, which is the probable source of her discomfort. This is the level above the fusion. Epidural steroid injections and facet injections were not beneficial, and the patient continued to have discomfort that is compatible with the changes shown on various studies. Distinct surgical pathology was not thought to be present.

Requested Service(s)

Celebrex, Carisoprodol, Hydro-APAP, Promethazine, Topamax, Effexor, 11/6/02-11/18/02

Decision

I disagree with the carrier's decision to deny the requested medications.

Rational

Around the time period in dispute, the patient had had various injections along with physical therapy, which were unsuccessful in dealing with her problem. Anti-inflammatories along with muscle relaxants, pain medication and anti depressive medications frequently are helpful in helping a pain problem such as the problem that this patient has.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.