

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 11-21-03.

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 Celebrex on 10-06-03 was 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 fees 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 date of service 10-06-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of January 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 15, 2004

RE: MDR Tracking #: M5-04-0734-01
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 an Orthopedic Surgeon reviewer, who is board certified in Orthopedic Surgery and has an ADL certification. The 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

The claimant has a history of chronic shoulder pain allegedly related to a work compensable injury that occurred on ____.

Requested Service(s)

Celebrex.

Decision

I agree with the insurance carrier that the requested service is not medically necessary.

Rationale/Basis for Decision

Generally, COX-2 inhibitors are indicated in the presence of significant peptic ulcer disease. Upon review of all documents provided, there is no documentation of significant peptic ulcer disease to indicate the medical necessity of the use of a COX-2 inhibitor non-steroidal anti-inflammatory medication. There is no rationale explaining why OTC nonsteroidal anti-inflammatory medications (Ibuprofen, Naprosyn) would be any less effective than use of COX-2 inhibitor in this clinical setting.