

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

SOAH DOCKET NO. 453-04-4528.M5

MDR Tracking Number: M5-04-1243-01

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 (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 January 2, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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 was the only issue** to be resolved. The Celebrex for 05-14-03 and 09-25-03 was found to be medically necessary. The Hydrocodone, Carisoprodol, and Temazepam for 01-08-03, 04-16-03, and 06-16-03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 05-14-03 and 09-25-03 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 19th day of February 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-04-1243-01
IRO Certificate Number: 5259

February 13, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

___ sustained a work related injury on ____. He has been seen by multiple physicians for ongoing symptoms. His treatments included medications, a TENS unit, chiropractic care, physical therapy and he was evaluated by x-rays, MRI scans, and electrodiagnostic tests. Apparently he completed a work hardening program in December 2001. He received MMI of 14% on 9/19/01 and one of 14% on 7/26/02. Specific records for much of his treatment were not submitted except for notes from Dr. ___ which were essentially medication refills. However, Dr. ___ submitted an excellent and detailed medical review of his case.

REQUESTED SERVICE(S)

Hydrocodone, Carisoprodol, Temazepam, Celebrex

DECISION

Deny Hydrocodone, Carisoprodol, Temazepam
Approve Celebrex

RATIONALE/BASIS FOR DECISION

Mr. ___ sustained his injury on ____. Essentially, he fails conservative treatment and becomes a chronic pain patient. Hydrocodone, Carisoprodol, and temazepam are medications that can readily cause tolerance, dependence, and addiction and are therefore inappropriate and excessive for this patient. This view point is supported by standard of care and accepted peer review literature. Celebrex can be used safely on a long term basis. Other than a note on 1/8/04 from Dr. ___ to prescribe Ultram and Ibuprofen, no clinical records show the treating physicians attempt to taper medications or change to an acceptable alternative after the acute phase of treatment was completed. Therefore, the prior denial for hydrocodone, temazepam and carisoprodol is upheld. The request for Celebrex is appropriate for chronic pain patients and is approved.