

MDR Tracking Number: M5-04-1503-01

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 12-12-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity.

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 prescription medications Hydrocodone and Methadone were not found to be medically necessary, reimbursement for dates of service 6-30-03 through 8-29-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28<sup>th</sup> day of July 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division  
DA/da

07/12/2004

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IRO #: 5284

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor with a specialty in Orthopedic Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any

of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ had a work related injury on \_\_\_ where she was pushing a resident in a wheelchair when her foot slipped and she twisted her back. She continued to be symptomatic and had diagnostic tests including MRI's, EmG's and discograms when she underwent an apparent two level 360 fusion of L4/5 and L5/S1 in March of 2000. She had some improvement but after 10 months she started having increased pain and was diagnosed with a failed fusion syndrome. She has been managed with Methadone and Neurontin. The records indicate a large gap in treatment from 12/27/01 through 9/8/03.

#### DISPUTED SERVICES

The disputed services include the medical necessity of Hydrocodone and Methadone.

#### DECISION

The reviewer agrees with the previous adverse determination.

#### BASIS FOR THE DECISION

The reviewer indicates the basis for decision is based upon the National Pain Educational Council, which notes that the medical necessity for the ongoing chronic pain treatment with both Methadone and Hydrocodone cannot be substantiated due to the large lapse in treatment of almost two years.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, Inc, dba \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,