

MDR Tracking Number: M5-04-1660-01

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 December 13, 2002.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. 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 the only issue** to be resolved. The opioid therapy, methadone, hydrocodone, neurontin, doxepin, diazepam and propranolol **were** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed treatment.

This Findings and Decision is hereby issued this 26<sup>th</sup> day of May 2004.

Patricia Rodriguez  
Medical Dispute Resolution Officer  
Medical Review Division

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 01-07-02 through 09-30-02 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 26<sup>th</sup> day of May 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/pr

## NOTICE OF INDEPENDENT REVIEW DECISION

May 5, 2004

### AMENDED LETTER

MDR Tracking #: M5-04-1660-01  
IRO Certificate #: IRO4326

The \_\_\_ 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 §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the rendered 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 a \_\_\_ physician reviewer who is board certified in Family Practice by the \_\_\_, licensed in Texas in \_\_\_ and who provides health care to injured workers. This is the same specialty as the treating physician. The \_\_\_ physician 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

This patient sustained a work-related injury on \_\_\_ when she fell at \_\_\_. The patient suffers from lumbar discopathy with left leg radiculopathy. She had multiple surgical procedures and evaluation following her injury. She has difficulty walking, standing or sitting for any length of time. She is also experiencing partial paralysis, dropping of her left foot and dragging of her left foot and toes. As part of the patient's chronic pain management, her treating physician has prescribed opioid therapy in the form of methodone, hydrocodone, neurontin and doxepin. In addition, the physician has prescribed diazepam and propranolol.

#### Requested Service(s)

Medications: opioid therapy, methadone, hydrocodone, neurontin, doxepin, diazepam and propranolol

#### Decision

It is determined that the medications, opioid therapy, methadone, hydrocodone, neurontin, doxepin, diazepam and propranolol are medically necessary.

#### Rationale/Basis for Decision

This patient had an injury to her back in \_\_\_. She had prior back problems and a spinal fusion. Her follow up indicated that she was doing well. She subsequently fell on \_\_\_.

Even though there was no x-ray evidence of fractures, the patient had increased pain and over the years has required pain clinic and chronic pain treatment with some stabilization.

One could question whether the fall in \_\_\_ caused additional problems. Certainly, the history is consistent with this, since the prior injury up to this point was doing well. The patient now needs the medications for her pain, based on her medical conditions and symptoms. Therefore, it is determined that the medications, opioid therapy, methadone, hydrocodone, neurontin, doxepin, diazepam and propranolol are medically necessary.

Sincerely,