

MDR Tracking Number: M5-04-1793-01

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 01-20-04.

The IRO reviewed Hydrocodone, Avinza Morphine and walking cane from 09-27-03 through 12-23-03 that were denied based upon "V".

The IRO concluded that Hydrocodone/APAP, Avinza, Morphine **were not** medically necessary from 09-27-03 through 12-23-03. The IRO concluded that the walking cane for date of service 11-23-03 **was** medically necessary.

On this basis, the total amount recommended for reimbursement (**\$19.99**) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision.

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) to the requestor within 20 days of receipt of this order. This Decision is applicable for date of service 11-23-03 in this dispute.

This Findings and Decision and Order are hereby issued this 2<sup>nd</sup> day of August 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

July 28, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION  
Amended Letter B**

**RE: MDR Tracking #: M5-04-1793-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by

the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in orthopedic surgery and is familiar with the condition and treatment options at issue in this appeal. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a female who sustained a work related injury on \_\_\_\_. The patient reported that while at work she tripped and fell, injuring her left arm and both knees. X-Rays of the left shoulder and both knees performed on 5/9/00 were reported to have revealed a non-displaced linear fracture involving the left shoulder at the left greater tuberosity. The patient began physical therapy three times a week on 5/11/00. The patient has undergone a MRI of the left knee on 6/27/00 and a MRI of the left shoulder on 9/6/00. On 3/8/01 the patient underwent left surgery consisting of an open decompression and acromioplasty, and on 8/14/01 the patient underwent diagnostic and operative arthroscopy of the left knee with left patellar release. The patient was treated with further physical therapy and medications. On 3/8/02 an MRI of the left shoulder was performed and an open decompression of the left shoulder, resection of the distal end of the clavicle and repair of a rotator cuff tear for impingement syndrome secondary to unstable acromioclavicular joint plus a 1cm tear of the rotator cuff, was performed on 4/30/02. The patient was treated postoperatively with physical therapy, chiropractic care, and medications. On 9/5/03 the patient was evaluated and was found to have crepitus with passive range of motion in the left shoulder, left knee crepitus with motion and evidence of arthroscopy scars, and diagnosed with intrinsic left shoulder and left knee disease with joint at multiple sites. The patient was treated with left shoulder and left knee intra-articular injections and physical therapy. Further treatment for this patient's condition has included oral pain medications.

### Requested Services

Hydrocodone/Apap, Avinza, Morphine from 9/27/03 through 12/23/03 and a walking cane purchased on 11/23/03.

### Documents and/or information used by the reviewer to reach a decision:

#### *Documents Submitted by Requestor:*

1. Peer Review 2/20/04
2. MRI report 9/6/00
3. EMG/NCV report 12/10/03
4. Daily Patient Records

*Documents Submitted by Respondent:*

1. Peer Review 3/16/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a female who sustained a work related injury to her left arm and both knees on \_\_\_\_. The \_\_\_ physician reviewer also noted that the patient had undergone left shoulder and left knee surgery, both followed by physical therapy. The \_\_\_ physician reviewer indicated that a walking cane was purchased to assist this patient with ambulation. The \_\_\_ physician reviewer explained that based on the description of MRI findings of the left knee, the walking cane is medically necessary and reasonable. The \_\_\_ physical reviewer further noted that the patient had been also treated with oral pain medications. The \_\_\_ physical reviewer explained that the narcotic pain medications in question were prescribed well after the left shoulder surgery performed on 4/30/02. The \_\_\_ physician reviewer also explained that narcotic use for pain is no longer indicated or medically necessary more than a year after surgery. Therefore, the \_\_\_ physician consultant concluded that the walking cane purchased on 11/23/03 was medically necessary to treat this patient's condition. The \_\_\_ physical consultant also concluded that the Hydrocodone/Apap, Avinza, Morphine from 9/27/03 through 12/23/03 were not medically necessary to treat this patient's condition.

Sincerely,