

THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-7292.M5

MDR Tracking Number: M5-04-2095-01

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 3-10-04.

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 prescription medications Hydrocodone/Apap and Carisoprodol dispensed from 3/10/03 through 5/19/03 were 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 dates of service 3/10/03 through 5/19/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of June 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

May 14, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M5-04-2095-01

___ 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 48 year-old female who sustained a work related injury on ____. The patient reported that while at work she injured her right knee, hip, hand, shoulder, low back and neck. The diagnoses for this patient have included cervical sprain, lumbar sprain, right shoulder sprain, and right knee sprain. The patient is being treated with oral medications consisting of Hydrocodone/apap for breakthrough pain, Carisoprodol-muscle relaxant, and has been recently prescribed Temazepam for insomnia.

Requested Services

Hydrocodone/Apap and Carisoprodol from 3/10/03 through 5/19/03.

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

Documents Submitted by Requestor.

1. Office notes 2/24/03 – 7/7/03

Documents Submitted by Respondent.

1. Peer review 5/15/03

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female who sustained a work related injury to her right knee, hip, hand, shoulder, low back and neck. The ___ physician reviewer indicated that the patient was diagnosed with a cervical sprain, lumbar sprain, shoulder sprain and knee sprain on ____, well over a year after the injury was sustained. The ___ physician reviewer noted that the patient underwent diagnostic studies that included a CT scan of the cervical and lumbar area, and a x-ray of the cervical and lumbar area. The ___ physician reviewer also noted that the patient's pain level was rated a 7/10 and that she was prescribed Lortab and Soma. The ___ physician reviewer indicated that the patient was seen by the treating physician 5 times between 3/24/03 and 5/19/03 with continued complaints of pain ranging from 6/10 – 9/10. The ___ physician reviewer noted that the patient continued with Lortab and Soma in addition to three other medications during this time, and continued to work 3-4 hours a day. The ___ physician reviewer explained that the patient's diagnoses based on the injury sustained on ___ was multiple strains and sprains. The ___ physician reviewer also explained that continued treatment for strains and sprains well over a year after the injury date, is not medically necessary. Therefore, the ___ physician consultant concluded that the Hydrocodone/Apap and Carisoprodol from 3/10/03 through 5/19/03 were not medically necessary to treat this patient's condition.

Sincerely,