

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 March 19, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The IRO reviewed prescriptions medication for Hydorocodone/APAP, Celebrex, Aciphex, Diazepam from 03-19-03 through 06-11-03 and **were found not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on the review of the disputed issues within the request, the Medical Review Division has determined that medical necessity was not the only issue to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division

On July 6, 2004, the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The carrier denied Hydro/APAP for date of service 09-03-03, with "E – Entitlement to benefits disputed". A review of the TWCC database reveals that a TWCC-21 was not filed with the Commission disputing compensability; therefore, this review will be based entirely upon the Medicare Fee Schedule. The Requestor submitted relevant documentation that supports service billed. Therefore, recommend reimbursement of \$108.84.

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 date of service 09-03-03 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 30th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 10, 2004

RE:

MDR Tracking #: M5-04-2220-01

IRO Certificate #: 5242

___ 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 Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed 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 an Orthopedic reviewer who is board certified and has an ADL certification. The 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

The claimant has a history of chronic neck and shoulder pain from an alleged work injury on ___.

Requested Service(s)

Hydrocodone/APAP, Celebrex, Aciphex, Diazepam for dates of service 3/19/03-6/11/03

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally, Hydrocodone and Diazepam are indicated for the relief of discomfort associated with acute painful musculoskeletal conditions generally associated with acute injury and peri-operative conditions. The claimant is working full time and exhibits a functional range of motion. Furthermore, an attempt to wean a patient from use of narcotic agents and muscle relaxants are generally indicated. There is no documentation of a clinical trial of weaning the claimant from use of narcotics and Valium.

Celebrex is generally indicated in the presence of documented gastrointestinal reflux disease or peptic ulcer disease. Aciphex is also generally indicated in the presence of documented gastroesophageal reflux disease and peptic ulcer disease. There is no documentation of gastroesophageal reflux disease or peptic ulcer disease in this clinical setting to indicate the medical necessity of Celebrex and Aciphex. There is no explanation why over the counter non-steroidal anti-inflammatory medications (Ibuprofen) would be any less effective than a Cox-II inhibitor. The documentation does not support the requested items are reasonable or medically necessary.