

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 4-13-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650** for the paid IRO fee. 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 prescription medications Cyclobenzaprine, Paxil, and Neurontin dispensed from 4/17/03 through 7/07/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 4/17/03 through 7/07/03 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 Decision and Order is hereby issued this 22<sup>nd</sup> day of June 2004.

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

### NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** June 2, 2004

**AMENDED DECISION**

**MDR Tracking #:** M5-04-2515-01  
**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 a Neurosurgeon reviewer (who is board certified in Neurosurgery) who 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**

It appears the claimant injured his back on \_\_\_. He subsequently underwent a lumbar laminectomy and fusion from L3 to S1 on 11/26/01. He apparently has had continued back pain since then which has been diagnosed as a failed back syndrome associated with neuropathic pain.

### **Requested Service(s)**

The appropriateness of using Cyclobenzaprine, Paxil, and Neurontin in his management by \_\_\_ between 4/17/03 and 7/7/03

### **Decision**

I disagree with the insurance carrier and find that the services in dispute are medically necessary.

### **Rationale/Basis for Decision**

Cyclobenzaprine is a muscle relaxant medication which is appropriate for a patient with chronic back pain with muscle spasm. Paxil is an antidepressive drug which is appropriate for patients who have depression from chronic pain which this claimant seems to have. The sticking point with the reviewers seems to be the drug Neurontin. As noted by the reviewers, Neurontin is generally prescribed as an anticonvulsant. However, it has also been well accepted and prescribed as a drug for the management of *neuropathic* pain. The claimant has been diagnosed by \_\_\_, a pain management specialist, as having neuropathic pain and there is nothing in the records which would negate that diagnosis.