

MDR Tracking Number: M5-04-2992-01

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 5-11-04.

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 Amitriptylin, Gabitril, Temazepam, Lorazepam, Carisoprodol, Topamax, Oxycontin CR, Roxicodone, and Ambien dispensed from 5/12/03 through 6/09/03 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, the request for reimbursement for dates of service 5/12/03 through 6/09/03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 16th day of August 2004.

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

August 4, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

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___ 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 anesthesiology 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 injured her right shoulder and fractured a rib when she fell from a desktop. The diagnoses for this patient have included right brachial plexitis and secondary right shoulder girdle myofascial pain. The patient is currently being treated with oral medications.

Requested Services

Medications-Amitriptylin, gabapril, temazepam, lorazepam, carisoprodol, topamax, oxycontin cr, roxicodone, and Ambien from 5/12/03 through 6/9/03

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

Documents Submitted by Requestor:

1. Letter of Medical Necessity 8/14/03, 7/29/03

Documents Submitted by Respondent:

1. Position statement 5/27/04
2. Medical record review 4/4/03

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 45 year-old female who sustained a work related injury to her right shoulder and fractured a rib on ____. The ___ physician reviewer indicated that the diagnoses for this patient's condition have included right brachial plexitis and right shoulder girdle myofascial pain. The ___ physician reviewer noted that the patient had been evaluated by neurology and has been under the care of a pain management specialist since 8/00. The ___ physician reviewer also noted that the patient has continued complaints of right shoulder pain although she has been maintained on oral medications. The ___ physician reviewer explained that the patient had been deemed to be at maximum medical improvement with a 7% impairment with the majority of that impairment related to limited range of motion in the right shoulder. The ___ physician reviewer also explained that there is no documentation provided indicating that the patient had been receiving any other form of treatment other than follow-up evaluations. The ___ physician reviewer further explained that there is no objective measure of effectiveness of pain relief and functional activity increase and that the patient is not presently on any anti-inflammatory medications. Therefore, the ___ physician consultant concluded that the Amitriptylin, gabapril, temazepam, lorazepam, carisoprodol, topamax, oxycontin cr, roxicodone, and Ambien from 5/12/03 through 6/9/03 were not medically necessary to treat this patient's condition.

Sincerely,