

MDR Tracking Number: M5-04-3136-01

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 (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 May 19, 2004.

The 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 Celebrex, Amitriptylene, and Hydrocodone/APAP were not found to be 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 was the only issue** to be resolved. As the Celebrex, Amitriptylene, and Hydrocodone/APAP were not found to be medically necessary, reimbursement for dates of service rendered 5/21/03 through 7/2/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 1<sup>st</sup> day of November 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

July 28, 2004

David Martinez  
TWCC Medical Dispute Resolution  
7551 Metro Center Suite 100  
Austin, TX 78744

Patient:  
TWCC #:  
MDR Tracking #: M5-04-3136-01  
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to

Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor with a specialty in Neurology. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_ suffered a work related injury on \_\_\_. He was struck by a backhoe bucket and was pinned against a brick wall. His left tibia and fibula were fractured and he required an ORIF on 7-20-2002. His surgery was performed by Dr. P. According to the report of Dr. D, \_\_\_ made slow steady progress but then had residual stiffness of his left ankle and knee and requested physical therapy which was denied by Dr. P. \_\_\_ then came under the care of Dr. H who performed physical therapy and Dr. W, who prescribed Celebrex, hydrocodone, and Elavil. Dr. W was suspicious about an internal derangement of the left knee and ankle. \_\_\_ saw Dr. S on 1-09-2003 for an IME. An FCE indicated ability to work at a heavy occupation, which was his pre-injury level of activity. He indicated that \_\_\_ had reached MMI as of 1-09-2003. He felt that no additional therapy, chiropractic visits or prescription medications were necessary. His pain and stiffness could be managed with over the counter medications. Dr. D's assessment, performed under auspices of a required Medical Evaluation, revealed no evidence of an internal derangement of the left knee or ankle. He thought \_\_\_ had disuse atrophy of the left lower extremity. His opinion was that no additional testing or treatment was necessary and that \_\_\_ could resume his pre-injury level of activity without restrictions or limitations.

#### DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of Celebrex, Amitriptylene, and Hydrocodone/APAP from 5-21-2003 to 7-02-2003.

#### DECISION

The reviewer agrees with the previous adverse determination.

## BASIS FOR THE DECISION

The medical documents submitted indicated that \_\_\_ had reached MMI as of 1-09-2003 and that both Drs. S and D felt that no further therapy, testing, or prescription medications were medically necessary. Clinically, \_\_\_ had shown good healing and an FCE performed on 1-09-2003 indicated ability to work at his previous heavy occupation. There are no residual physical deficits which would preclude \_\_\_ from returning to his previous occupation. There is no clear indication of a process which has not or would not respond to over the counter analgesics.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,