

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-2144.M5

MDR Tracking Number: M5-04-4271-01

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 August 17, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for prescription medications for dates of service 09/11/03 through 10/14/03. The IRO agrees with the previous determination that the prescription medication was 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 was the only issue 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 09/11/03 through 10/14/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO decision

October 19, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-4271-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- 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 neurosurgery 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 58 year-old male who sustained a work related injury on ----- . The patient reported that while at work he slipped on a wet sidewalk injuring his low back. The patient was initially treated with conservative care. The patient had reportedly undergone an L3 percutaneous discectomy in 3/97, an L3-4 fusion on 1/6/00 and a PLIF at L3 with bone stimulator in 2/01. The patient had reported continued complaints of pain and had been treated with Carisoprodol, Ultracet, Alprazolam, Oxycontin and Imitrex.

Requested Services

Prescription medications Carisoprodol, Ultracet, Alprazolam, Oxycontin and Imitrex from 9/11/03 through 10/14/03.

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

Documents Submitted by Requestor:

1. Letters of Medical Necessity 2/21/03, 3/7/03, 10/22/03, 1/25/04

Documents Submitted by Respondent:

1. Required Medical Examination 3/25/04
2. Peer Review 8/6/03

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a 58 year-old male who sustained a work related injury to his low back on ----- . The ----- physician reviewer also noted that the patient had initially been treated with conservative care followed by a L3 percutaneous discectomy in 3/97, an L3-4 fusion on 1/6/00 and a PLIF at L3 with bone stimulator in 2/01. The ----- physician reviewer further noted that recent treatment of this patient's condition has included prescription medications consisting of Carisoprodol, Ultracet, Alprazolam, Oxycontin and Imitrex. The ----- physician reviewer explained that long-term pain control is medically necessary for this patient. However, the ----- physician reviewer also explained that there is no indication that the use of narcotics for long-term pain control has been proven productive or efficacious. The ----- physician reviewer further explained that a stable regimen of oral antiinflammatories has been tried for this patient. Therefore, the ----- physician consultant concluded that the prescription medications Carisoprodol, Ultracet, Alprazolam, Oxycontin and Imitrex from 9/11/03 through 10/14/03 were not medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department