

MDR Tracking Number: M5-05-0917-01

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 11-15-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity.

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 co-pay for prescriptions from 6-24-04 through 8-2-04 was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Pursuant to 413.019 of the Act, the Medical Review Division hereby **ORDERS** the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c); in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c)(6); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 6-24-04 through 8-2-04 in this dispute.

This Order is hereby issued this 8<sup>th</sup> day of March 2005.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

Enclosure: IRO decision



7600 Chevy Chase, Suite 400  
Austin, Texas 78752  
Phone: (512) 371-8100  
Fax: (800) 580-3123

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** February 28, 2005

**To The Attention Of:**

TWCC  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-16091

**RE: Injured Worker:**

**MDR Tracking #:** M5-05-0917-01

**IRO Certificate #:** 5242

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

Forté 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 Physical Medicine/Rehabilitation reviewer (who is board certified in physical medicine/rehabilitation and subspecialty board certified in pain medicine) 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.

**Submitted by Requester:**

- Physical medicine physician office notes by Patrick W. Mulroy, M.D. of Lone Star Physical Medicine and Rehabilitation including the initial physical medicine evaluation note of November 15, 1999 and subsequent physical medicine follow-up notes up to and including September 24, 2004.

**Submitted by Respondent:**

- KNS General Peer Review, physical medicine peer review by Eddie Sassoon, M.D. dated August 22, 2002

## **Clinical History**

This 56 year old right handed female was working as a customer service representative for on \_\_\_ noted bilateral upper extremity, hand and forearm pain, more prominently on the right. She subsequently underwent a right carpal tunnel surgical decompression of January 10, 1997 and a right first/fifth digit trigger finger releases of June 1997. She developed chronic bilateral upper extremity myofascial pain and came under the care of Dr. Patrick W. Mulroy for physical medicine management as of November 15, 1999. Currently the claimant is seen by Dr. Mulroy at four month intervals. She is prescribed a chronic analgesic medication regimen which has remained stable including: Lortab 7.5 mg. tablets, one 3 times per day and Colace 1 tablet twice daily as needed for constipation secondary to the prescribed narcotic analgesic medication.

## **Requested Service(s)**

Co-pay for prescriptions. Denied by carrier per peer review as unnecessary treatment with EOB code U for dates of service 6/24/04 - 8/2/04.

## **Decision**

I disagree with the insurance carrier and find that the prescribed Lortab 7.5 mg. tablets, one 3 times per day is medically necessary and reasonable for management of the compensable work injury dated \_\_\_\_. The copay for the prescriptions denied by the carrier should therefore be covered.

## **Rationale/Basis for Decision**

The claimant is receiving a chronic narcotic analgesic medication regimen of Lortab 7.5 mg. tablets one 3 times per day and has remained stable over an extended period of time on this medication regimen which provides improved activity tolerance and quality of life for the claimant. Dr. Mulroy documents that the Lortab 7.5 mg. tablets 3 times per day provides adequate therapeutic analgesia with regard to the bilateral upper extremity chronic myofascial pain that the claimant is demonstrating due to the compensable work injury. Chronic maintenance narcotic analgesic medications for chronic disabling benign musculoskeletal conditions are considered standard of care for physical medicine/rehabilitation specialists and pain management specialists.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 28<sup>th</sup> day of February 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder