

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-05-4823.M5

MDR Tracking Number: M5-05-1225-01

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 12-21-04.

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 Oxycontin-CR 20 mg., Bextra 20 mg., Carisoprodol 350 mg., Topamax 10 mg. and Hydroco/APAP 10/500 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, reimbursement for dates of service from 01-09-04 to 02-23-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 11th day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

February 9, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1225-01
TWCC #:
Injured Employee:
Requestor: Highpoint Pharmacy
Respondent: State Office of Risk Management
MAXIMUS Case #: TW05-0004

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who sustained a work related injury on _____. She reported that she was involved in a motor vehicle accident and developed headaches and low back pain by the following morning. She was initially treated with a soft collar and then physical therapy. The patient underwent a C5-6 ACDF in 1999. A letter from her neurosurgeon dated 10/24/03 indicated that the patient's diagnoses were chronic cervical and lumbar radiculopathy, bilateral carpal tunnel syndrome confirmed by EMG, lumbar facet syndrome, post-traumatic headaches with post-concussion syndrome and memory loss, lumbar trigger points, C4-5 bulge, C5-6 bulge, C6-7 bulge and IDDS at L4-5 and L5-S1 confirmed by discogram. A letter from her neurosurgeon dated 6/14/04 indicated that she had chronic cervical radiculopathy, disc bulges at C4-5 and C6-7, and internal disc disruption syndrome at L4-5 and L5-S1 confirmed by lumbar discography. It noted that EMG revealed right L5 radiculopathy. It also noted that the patient had continued neck pain and low back pain. She has been treated with physical therapy, surgery, epidural steroid injections, trigger point injections and medications.

Requested Services

Oxycontin-CR 20 mg, Bextra 20 mg, Carisprodol 350 mg, Topamax 10 mg, Hydroco/APAP 10/500 from 1/9/04 to 2/23/04.

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

Documents Submitted by Requestor.

1. History, physical and neurological examination report dated 7/17/98 and records from the patient's neurosurgeon from 1/17/03 to 11/7/03
2. Letters from the member's neurosurgeon dated 10/20/03, 10/24/03, 4/6/04, 4/7/04, 4/12/04 4/27/04, 5/19/04, 6/14/04, and 7/1/04
3. Report from a cervical and lumbar myelogram and CT performed on 12/7/98

Documents Submitted by Respondent:

1. Report from a medical records review dated 11/11/03
2. Records from the patient's neurosurgeon from 7/17/98 to 8/23/04
3. Letters from the patient's neurosurgeon dated 8/8/01,
4. Functional Capacity Evaluation Summary dated 8/14/01
5. Initial medical reports dated 5/26/98 12/13/99, 6/22/00, and 5/22/98
6. Initial evaluation dated 12/13/99
7. Medical report describing evaluation performed on 6/21/00
8. Impairment rating report dated 5/17/00
9. Physical therapy records from 5/22/98 and from 7/27/98 to 9/10/98
10. Report from a MRI of the cervical spine dated 6/15/98
11. Progress notes from 6/5/98 to 6/19/98
12. Initial consultation report dated 7/13/04, procedure note dated 7/28/04 and letters regarding visits on 8/3/04
13. Report from CT of the patient's cervical spine dated 8/17/98
14. Functional Capacity Evaluation report from September 1998
15. Operative report dated 11/3/98
16. Pain management evaluation dated 9/16/98 and 9/24/98
17. Work hardening clinical interview report dated 9/21/98
18. Report from lumbar discogram and CT performed on 1/22/98
19. Letter regarding orthopedic surgeon evaluation performed on 1/21/99
20. EMG report dated 11/14/03
21. Letter regarding independent medical evaluation performed on 8/6/04
22. Functional Capacity Evaluation Report dated 8/12/04

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury to her low back and head on _____. The MAXIMUS physician reviewer also noted that the diagnoses for this patient's condition have included chronic cervical and lumbar radiculopathy, bilateral carpal tunnel syndrome confirmed by EMG, lumbar facet syndrome, post traumatic headaches with post concussion syndrome and memory loss, lumbar trigger points, C4-5 bulge, C5-6 bulge, C6-7 bulge and IDDS at L4-5 and L5-S1 confirmed by discogram. The MAXIMUS physician reviewer further noted that the patient has continued neck and low back pain and has been treated with physical therapy, surgery, epidural steroid injections, trigger point injections and medications consisting of Oxycontin-CR 20 mg, Bextra 20 mg, Carisprodol 350 mg, Topamax 10 mg, and Hydroco/APAP. The MAXIMUS physician reviewer indicated that the medications used to treat this patient's condition are not prescribed for long-term chronic use for pain management. Therefore, the MAXIMUS physician consultant concluded that the

Oxycontin-CR 20 mg, Bextra 20 mg, Carisprodol 350 mg, Topamax 10 mg, Hydroco/APAP 10/500 from 1/9/04 to 2/23/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department