

NOTICE OF INDEPENDENT REVIEW DECISION

**AMENDED LETTER**

Note: MDR Tracking #

October 24, 2002

RE: MDR Tracking #: M2-03-0062-01  
IRO Certificate #: 4326

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

\_\_\_ 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 \_\_\_ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The \_\_\_ physician 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.

Clinical History

This 50 year old male sustained a work-related back and neck injury on \_\_\_ when he fell while restraining an inmate. An MRI confirmed disc herniation at C4-7 and L3-5. An EMG and nerve conduction test confirmed irritation at the nerve root. The patient has received conservative treatment including physical therapy, injections, and medications. He continues to complain of lower extremity pain, numbness and tingling. The treating orthopedist has recommended a lumbar myelogram, post myelogram CT, pain management program for 30 days, and individual psychotherapy.

Requested Service(s)

Lumbar myelogram, post myelogram CT, pain management program for 30 days, and individual psychotherapy

Decision

It has been determined that the lumbar myelogram, post myelogram CT, pain management program for 30 days, and individual psychotherapy are not medically necessary.

Rationale/Basis for Decision

Lumbar myelogram and post myelogram CT are studies most commonly considered pre-operatively. As no specific surgical procedure is being reasonably considered, there is no reasonable indication for this study. Under the current circumstances, the study would be for screening and would have little or no likelihood of being beneficial. Therefore, the lumbar myelogram and post myelogram CT are not medically necessary.

This patient's symptoms have been present for six years. He has been through at least two pain management programs without success. There is no indication that another pain management program would have any likelihood of success when two others have failed. Therefore, the pain management program for 30 days is not medically necessary.

This patient participated in group therapy in prior pain management programs. According to the documentation submitted for review, his attendance was adequate and he did participate, however, it appears that he gained little insight into the psychological factors contributing to his pain syndrome. There is no indication that individual psychotherapy would have any significant likelihood of success. Therefore, individual psychotherapy is not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,