

May 14, 2003

Re: MDR #: M2-03-0858-01  
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Certified in Chiropractic medicine.

Clinical History:

This 40-year-old male claimant suffered traumatic work-related injury on \_\_\_\_\_. The accident resulted in burst fractures in the thoracic and lumbar spine causing fragments and disc contents to press into the thecal sac.

CT scan of the lumbar spine on 06/27/01 showed compression fracture of L-1 with 30% loss of vertebral body height with a slight 3-4 mm posteriorly displaced left-sided fracture fragment with moderate focal compression on the thecal sac; L5-S1 2-3 mm circumferential posterocentrally bulged with encroachment on the thecal sac. CT scan of the thoracic spine on 06/27/01 revealed a comminuted fracture at T-11 with a 2.0 mm shallow diffuse posteriorly bulged disc and a T-12 fracture with a 2.0 mm disc bulge with indentation on the thecal sac.

Repeat CT scan of the lumbar/thoracic spine on 11/29/01 showed stenosis of the right-sided nerve root at T10-T11, T11-T12, and T12-L1. Bone scan on 04/03/02 showed increased signal uptake over the costovertebral junction of T-10, T-11, and T-12, indicative of healed fractures. Repeat CT scan of the lumbar spine on 04/03/02 showed a healed fracture of the T-10 and T-11 transverse processes, anterior wedge compression deformities at T-11, T-12, and L-1, minimally diffuse disc bulging at L3-4.

FCE on 06/18/02 revealed that the patient was unable to meet the functional demands of his occupation, and a work hardening program was recommended. The patient was given a 10% whole-person impairment rating on 11/01/02 and was placed at maximum medical improvement (MMI).

Disputed Services:

Neuropsychiatric evaluation.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that this evaluation is medically necessary in this case.

Rationale for Decision:

The injury mechanism alone of this patient warrants the application of psychological services. The medical record shows no clinical justification for a treatment algorithm that does not include neuropsychological evaluation testing.

The patient lost consciousness prior to the accident and a thorough investigation to rule in/out post-concussive trauma and brain injury must be implemented.

- *Gwendolijne G.M., et al. Clinical Practice Guideline for Physiotherapy of Patients with Whiplash Associated Disorders, Spine, Vol. 27, No. 4, pp. 412-422.*
- *Practice Guidelines for Psychiatric Consultation in the General Medical Setting. Psychosomatics, 1999, Jul-Aug. 39(4): 8-30.*
- *Unremitting Low Back Pain, North American Spine Society Phase III Clinical Guidelines for Multi-Disciplinary Spine Care Specialists. North American Spine Society; 2000, 96 p.*

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 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.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on May 14, 2003.

Sincerely,