

NOTICE OF INDEPENDENT REVIEW DECISION

December 29, 2003

MDR Tracking #: M2-04-0509-01
IRO Certificate #:IRO4326

The ___ 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 pain management 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 patient sustained an injury on ___ when he twisted his left hip while pulling a pallet out of a cooler on a slippery floor. He was diagnosed with severe hamstring strain and sacroiliac joint dysfunction. He underwent a course of physical therapy, epidural steroid, sacroiliac, and facet injections, and muscle relaxant, narcotic, and anti-inflammatory medications. Imaging studies revealed grade 1 spondylothesis at L5-S1 and thecal sac and nerve root compression at L4-5. He underwent a lumbar laminectomy at L5-S1 and posterior lumbar interbody fusion with autologous bone graft on 08/16/01. He has had continuing problems since the surgery and has now gone back to the pain management physician for treatment options.

Requested Service(s)

Intrathecal morphine pump trial

Decision

It is determined that the proposed intrathecal morphine pump trial is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has chronic, intractable pain, which has not responded to extensive interventions including physical therapy, multiple medications including opiates, multiple injection procedures, a laminectomy with fusion, and a multidisciplinary pain program.

He obviously continues to have pain according to the medical records. Patient criteria for intrathecal narcotic trials, according to Elliot Krames in the Journal of Pain and Symptom Management, 1996 include: failure of conservative treatment, observable pathology that is concordant with the pain complaint, further surgical intervention is not indicated, no serious untreated drug habituation, psychological evaluation and clearance for implantation and no contraindication on implantation.

The patient had a psychological evaluation on 07/17/02, which indicated, "he approached the test in an open and honest manner". It also showed his depression and anxiety scores to be average for a pain patient. His somatization scores indicated that "health related concerns do not occupy an excessive amount of his attention". An independent evaluation done 09/06/02 by a designated doctor shows the "patient was pleasant and cooperative throughout the entire examination". The patient meets all of the above criteria. Therefore, it is determined that the proposed intrathecal morphine pump trial is 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** (ten) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,