

October 20, 2004

MDR Tracking #: M2-05-0107-01

IRO Certificate #: 5284

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor who is board certified in Anesthesia and Pain Management. The reviewer is on the TWCC ADL. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

The medical records reviewed for this case are:

1. Texas Worker's Compensation Commission – Medical Dispute Resolution
2. Office records from \_\_\_
3. Records from \_\_\_
4. Included in the insurance carrier files were reports from multiple physicians, operative reports, radiological reports, and physical therapy notes.

\_\_\_ sustained an injury while at work on \_\_\_. She eventually underwent an anterior cervical discectomy and fusion at C3 and C4 as well as an anterior cervical instrumentation at C3 and C4. The patient continued to have pain despite undergoing physical therapy, oral analgesics, and cervical epidural steroid injections. The patient underwent a dorsal column stimulator trial and noted good relief of her right and left radicular arm symptoms; however, she did not get relief of her neck and shoulder pain symptoms. As a result, a permanent dorsal column stimulator implantation was not undertaken. \_\_\_ recommended following up with a spinal narcotic trial with possible morphine pump implantation. From the medical records presented, the patient has continued to use Neurontin, amitriptyline, and Hydrocodone for pain relief. The physician of the insurance carrier, \_\_\_, dated 9-23-2004 states that they are denying this request for a morphine pump trial based on the fact that the claimant has failed a trial of spinal stimulation. Therefore,

she may not benefit from the use of a morphine pump. The request was determined not to be medically necessary.

#### REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a morphine pain pump trial.

#### DECISION

The reviewer agrees with the previous adverse determination.

#### BASIS FOR THE DECISION

This patient carries the diagnosis of failed back syndrome and reports pain over the neck, head, arms, shoulder, and upper back. She has not noted adequate relief following cervical spinal surgery, a spinal cord stimulator trial, as well as her current medications and physical therapy. There are no reports from the pain specialists treating \_\_\_ of any attempt to utilize more potent medications for improvement in her pain symptoms. The reviewer states that a morphine pump trial at this point is not medically indicated since this procedure is usually done when multiple potent analgesics have been tried and either have not adequately reduced the patient's pain or have caused intolerable side effects.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy. \_\_\_ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

#### **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.

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

In the case of other *prospective (preauthorization) medical necessity* disputes 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 a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 21st day of October, 2004**