

November 18, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0267-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

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

----- 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 ----- 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 anesthesiology and is familiar with the condition and treatment options at issue in this appeal. The ----- 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 ----- for independent review. In addition, the ----- physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 57 year-old female who sustained a work related injury on ----- . The patient reported that while at work she injured her back lifting a heavy object. The patient had undergone back surgery in 1991 and 1992. The patient had also been treated with physical therapy and injections for treatment of her pain. The patient has continued complaints of lower back pain radiating into her right hip and into her right lower extremity. Current treatment for this patient's condition has included conservative care consisting of Neurontin, Elavil, Zanaflex, and Hydrocodone. A trial of an intrathecal morphine pump has been requested for further treatment of this patient's condition.

Requested Services

Intrathecal Morphine Pump trial.

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

Documents Submitted by Requestor:

1. Contact Notes 6/30/04 - 10/7/04
2. Letter of medical necessity 9/27/04
3. Progress Notes 5/6/04 – 9/23/04
4. History and Physical 3/22/04

Documents Submitted by Respondent:

1. Progress Notes 3/22/04 – 7/21/04
2. Assessment 5/17/04
3. Impairment Rating 6/10/93
4. Required Medical Exam 10/11/00
5. Psychological Evaluation 9/10/04
6. CT report 12/28/99.

Decision

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

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a 57 year-old female who sustained a work related injury to her back on -----. The ----- physician reviewer indicated that the patient had undergone 2 back surgeries and has been treated with physical therapy, medications, and injection therapy. The ----- physician reviewer noted that the patient continues with complaints of low back pain and that an intrathecal morphine pump trial has been recommended for further treatment of this patient's condition. The ----- physician reviewer indicated that the patient had undergone a psychological evaluation and has a significant Pain Disorder with psychological and medical factors. The ----- physician reviewer explained that there is no documentation that the patient has tried and failed a multidisciplinary Chronic Pain Management Program. The ----- physician reviewer noted that the patient's pain management specialist had initiated a request for a Chronic Pain Management Program and that the program was further recommended by the psychologist who performed an evaluation in 5/04. The ----- physician reviewer indicated that the conclusion at the time of this request was that a comprehensive pain management program had the potential to reduce medication reliance, psychiatric symptoms and the need for further surgical interventions. The ----- physician reviewer explained that a pain management program would be appropriate treatment for this patient's condition before further invasive therapy is tried and the continued use of opioid medications. Therefore, the ----- physician consultant concluded that the requested intrathecal morphine pump trial is not medically necessary to treat this patient's condition at this time.

This decision 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)** 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 a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744

Fax: 512-804-4011

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,

State Appeals Department

cc: Texas Workers Compensation Commission

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 this 18th day of November 2004.

Signature of IRO Employee

Name