

NOTICE OF INDEPENDENT REVIEW DECISION

April 11, 2002

Requestor

Respondent

RE:

Injured Worker:

MDR Tracking #: M2-02-0506-01

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 neurosurgery 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.

The _____ physician reviewer has determined that the cervical and lumbar myelogram with CT scan is medically necessary for treatment of the patient's condition. Therefore, _____ disagrees with the previous adverse determination. The specific reasons including the clinical basis for this determination are as follows:

This 43 year old female sustained a back injury on ___ when she fell forward while assisting a patient out of a bathtub. The patient complains of back pain from the cervical spine down her buttock with pain radiating to her left arm. She also complains of pain down the right buttock to the right hip, thigh and knee. As part of the patient's evaluation and treatment, the treating physician has ordered a cervical and lumbar myelogram with CT scan. Cervical and lumbar myelogram with CT scan is an acceptable and appropriate diagnostic radiographic procedure for patients such as this. Therefore, it is determined that the cervical and lumbar myelogram with CT scan is a medically indicated diagnostic tool and should be an integral part of this patient's evaluation and treatment plan.

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. A request for 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, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, Texas 78704-0012.

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

Sincerely,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

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 _____ day of _____ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: