

NOTICE OF INDEPENDENT REVIEW DECISION

May 30, 2002

Requestor

Respondent

RE: Injured Worker:

MDR Tracking #: M2-02-0620-01

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 physical medicine and rehabilitation 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 58 year old male sustained a low back injury when an 18 wheeler that he was driving was involved in a motor vehicle accident on ____ and turned on its side. The patient complained of lower thoracic pain. The treating physician obtained a CT scan of the thoracic spine on 01/16/02, which revealed diffuse degenerative changes but no fracture. Due to the patient's duration of symptoms without improvement, the treating physician has recommended that the patient undergo a MRI of the thoracic spine.

Requested Service(s)

MRI of the thoracic spine.

Decision

It is determined that a MRI of the thoracic spine is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

A CT scan of the patient's thoracic spine revealed good bony definition, ruled out a vertebral fracture, and indicated degenerative changes. However, a MRI will reveal better definition of the vertebral discs. A herniated nucleus pulposus of the thoracic spine may be the cause of the patient's persistent back pain even in the absence of long tract signs or radiculopathy. Therefore, it is determined that a MRI of the thoracic spine is a medically indicated diagnostic tool and should be an integral part of this patient's 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: