

NOTICE OF INDEPENDENT REVIEW DECISION

October 4, 2002

RE: MDR Tracking #: M2-02-1169-01
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 neurology 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 55 year old female sustained a work related injury on ___. The patient slipped, fell and subsequently developed back and neck pain with evidence of L5 compromise on the right. An MRI revealed a disk bulge and osteophytes at C4-5, C5-6 and C6-7. She also has a disk herniation at L5-S1. An EMG revealed chronic L5 radiculopathy on the right. The physical examination revealed reduced range of motion of the cervical spine with straight leg raising bilaterally to 50 degrees. The patient complains of shooting pain down her left hip and into her knee. The patient's last MRI was done on 07/10/01 and the treating physician is recommending that the patient have a repeat lumbar MRI.

Requested Service(s)

Repeat lumbar MRI

Decision

It is determined that a repeat lumbar MRI is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Spondylosis and spinal disc related pathology can change over time, certainly within one year. Given that the patient has radiculopathic complaints, it is appropriate to obtain radiographic testing in order to rule out worsening of the existing pathology, disc fragments, or other abnormalities that would mandate a change in the patient's therapy. Therefore, the repeat MRI 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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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,