

February 11, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0503-01
IRO Certificate No.: 5348

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ 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 ___ external review panel. This physician is a board certified neurosurgeon. ___ 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, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 56 year-old female who sustained a work related injury on ___. The patient reported that while at work she was lifting heavy boxes to fill an order when she experienced back, shoulder, and arm pain. The patient has had X-Rays, and MRI, and a lumbar myelogram with CT scan following. The patient has undergone decompression at L4-S1, and placement of Brantigan cages at L4-L5, L5-S1, left L4, L5, S1 screws and right L4-S1 screws. She has also had active therapy. The patient complains of low back spasms and pain in both calves and feet.

Requested Services

CT Myelogram.

Decision

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

Rationale/Basis for Decision

___ physician reviewer noted that the patient sustained a work related injury to her back on ___. ___ physician reviewer also noted that the patient suffers from back, shoulder, and arm pain related to this injury. ___ physician reviewer indicated that the patient underwent surgery for back and leg pain. However, ___ physician reviewer noted that her leg and back pain are persisting. ___ physician reviewer explained that it is imperative to determine if the lesions that

were intended addressed by the original surgery were actually addressed or if the lesions were missed. Therefore, ___ physician consultant concluded that the CT Myelogram is medically necessary for diagnosis and treatment of this patient's condition.

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
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 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,

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 11th day of February 2003.