

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0407-01
IRO Certificate No.: 5259

January 21, 2004

An independent review of the above-referenced case has been completed by a neurosurgeon medical physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Notice of Independent Review Determination

CLINICAL HISTORY

This patient is a 31-year old female who sustained a work related accident on ___ and subsequently developed back pain, right buttock and right leg pain with paresthesias of the right heel. Neurological examination revealed that she had no neurological deficits. MRI 9/10/02 was severely degraded by motion artifact according to the evaluating surgeon who recommended a CT myelogram. This was denied by the carrier.

REQUESTED SERVICE(S)

CT myelogram L-spine.

DECISION

The CT myelogram is recommended as a diagnostic option.

RATIONALE/BASIS FOR DECISION

CT myelogram is widely accepted as the gold standard in evaluation for compression of the neural elements in the lumbar spine. MRI is performed more frequently due to its non-invasive technique.

However, some patients are not able to tolerate the confined environment of the MRI scanner and subsequently the images are degraded by patient movement. The CT scan is better tolerated by most patients due to decreased scan time and more open environment.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

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) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with Commission Rule 102.4(h), 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 22nd day of January 2004.