

May 10, 2004

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-04-1152-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Radiology. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ an employee of the ___, was originally injured on the job in ___ while lifting students. She has had chronic intermittent back pain ever since, and has had multiple treatment plans with some improvement, but followed by recurrence of her symptoms. A thoracic spine MRI dated 05/20/97 (___ months post injury) showed mild degenerative changes but no other abnormality. A cervical spine MRI on 04/22/98 (18 months post injury) was "unremarkable." A recent H&P note by ___ details past treatment plans, including physical therapy, steroid, trigger point and facet injections. Her physical exam showed good range of motion, normal muscle strength in the upper extremities, normal pinprick and reflex testing.

REQUESTED SERVICE

A repeat thoracic MRI is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

It is clear that muscular injury or strain occurred on the job on _____. It is also clear that the thoracic MRI done seven months post-injury failed to demonstrate any abnormality that would be related to her injury. "Mild degenerative changes" would not be related to the muscular injury seven months prior, and would be pre-existing.

It is also clear that this patient's complaints and symptoms have "waxed and waned" over the years, depending on types of therapy and time from therapy. Her most recent neurosurgical examination revealed no acute neurological findings or other reasons to suggest a change had occurred in this patient's complaints or examination.

Any findings on a new MRI would likely be unrelated to the injury, since the original MRI was unrevealing. While a repeat MRI may be desirable because of continuing symptoms, it is not medically necessary.

_____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. _____ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of _____, I certify that there is no known conflict between the reviewer, _____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

_____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to 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 (28 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)** calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

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

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 10th day of May 2004.