



# Texas Medical Foundation

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**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:  
SOAH DOCKET NO. 453-05-4142.M2**

## NOTICE OF INDEPENDENT REVIEW DECISION

December 28, 2004

### Requestor

Dr. P, DC  
Attn: \_\_\_\_\_  
1530 Avenue O  
Huntsville, TX 77340

### Respondent

ARCFMI  
Attn: \_\_\_\_\_  
P.O. Box 115114  
Carrollton, TX 75011-5114

RE: Injured Worker:  
MDR Tracking #: M2-05-0434-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional 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 TMF 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 36 year-old female injured her low back on \_\_\_ when she was picking up an empty palette and left a sharp pain in her back and left leg. She has been treated with medications and therapy.

### Requested Service(s)

Proposed 3 level lumbar discogram and post discogram computer tomography

### Decision

It is determined that there is medical necessity for the proposed 3 level lumbar discogram and post discogram computer tomography to treat this patient's medical condition.

### Rationale/Basis for Decision

Medical record documentation indicates an aggressive treatment program was performed including chiropractic care, physical therapy and injections. She has also completed a chronic pain program and continues to experience problems.

This patient's continual condition falls within the criteria established in the national treatment guidelines. There is sufficient documentation provided to clinically justify the treatment rendered as well as to clinically support the requested procedure. The discogram will provide appropriate documentation as to her current condition and serve as a guide for the next course of action. Therefore, the proposed 3 level lumbar discogram and post discogram computer tomography are medically necessary to treat this patient's medical condition.

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** (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 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, Fax: 512-804-4011.

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

Sincerely,

Director of Medical Assessment

GBS:vn

Attachment

cc: \_\_\_\_\_, Injured Worker  
Program Administrator, Medical Review Division, TWCC

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 27<sup>th</sup> day of December 2004.

Signature of IRO Employee:

Printed Name of IRO Employee:

## Information Submitted to TMF for TWCC Review

**Patient Name:**

**TWCC ID #: M2-05-0434-01**

### **Information Submitted by Requestor:**

- Doctors Position
- Progress Notes
- Diagnostic Tests

### **Information Submitted by Respondent:**

- Progress Notes
- Designated Doctor Examination
- Reconsiderations
- Consults
- Required Medical Examination
- Pain Management
- Procedures
- Diagnostic Tests
- Physical Therapy Notes
- Claims and Miscellaneous