Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

January 10, 2005

Requestor

Dr. P, DC
ATTN: Dennis Moehr
1530 Avenue O
Huntsville, TX 77340

Respondent

TPS Joint Self Insurance Funds
ATTN: Robert Josey
P.O. Box 162443
Austin, TX 78716

RE: Injured Worker:
MDR Tracking #: M2-05-0445-01
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 Medicine. 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 27 year-old female injured her low back with pain radiating to bother legs on ___. She also complains of occasional urine and stool incontinence. Magnetic resonance imaging of the lumbar spine demonstrated disc herniation at L5-S1 that appeared to be compromising S1 nerve roots bilaterally. She has been treated with therapy, pain management and medications.

Requested Service(s)

Proposed 3 level lumbar discogram, post discogram computed tomographic (CT) scan

Decision

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

Rationale/Basis for Decision

There is a sufficient amount of literature with regard to this procedure. This injured employee's continual condition falls within the criteria as established in the national treatment guidelines. There is sufficient documentation to indicate that the requested procedure is medically necessary and it will provide appropriate documentation as to her current condition. Therefore, the proposed 3 level lumbar discogram, post discogram CT is 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
Rosalinda Lopez, 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 10th day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-0445-01

Information Submitted by Requestor:

- Office Visit Notes
- Diagnostic Tests
- Designated Doctor Report

Information Submitted by Respondent:

- Claims