Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 · 901 Mopac Expressway South · Austin, Texas 78746-5799
phone 512-329-6610 · fax 512-327-7159 · www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

April 21, 2005

Requestor

Respondent

Financial Insurance Co. c/o Harris & Harris
ATTN: Wisteria Hutchenson
Fax #: (512) 346-2539

RE: Injured Worker:
MDR Tracking #: M2-05-0860-01
IRO Certificate #: IRO 4326

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 TMF physician reviewer who is board certified in Orthopedic Surgery, by the American Board of Orthopaedic Surgery, Inc. licensed by the Texas State Board of Medical Examiners (TSBME) in 1978, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer 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 32 year-old male injured his back on ___ while lifting an 80-pound heater from the back of a truck. He also complains of right lower extremity pain that radiates on the anterior and medial aspect of the thigh and intermittently to the posterior aspect of the calf. He has been treated with therapy, medications, and epidural injections.

Requested Service(s)

Lumbar discogram with computed tomographic scan

Decision

It is determined that there is no medical necessity for the lumbar discogram with computed tomographic scan to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient has had extensive treatment for more than a year. A lumbar discogram with computed tomographic is a preoperative study and there is no indication this patient has received a recommendation for surgery. It is unclear how this study might be of benefit to this patient. Therefore, the lumbar discogram with computed tomographic scan is not 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,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

cc: 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 21st day of April 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-0860-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests

Information Submitted by Respondent:

- Claims