

NOTICE OF INDEPENDENT REVIEW DECISION

July 25, 2005

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Requestor

James Guess, MD
ATTN: Tracy A.
4780 N. Josey
Carrollton, TX 75010

Respondent

Service Lloyds Insurance Co.
ATTN: Robert Josey
P.O. Box 162443
Austin, TX 78716

RE: Injured Worker:
MDR Tracking #: M2-05-1901-01
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 TMF physician reviewer who is board certified in Orthopedic Surgery, by the American Board of Orthopaedic Surgery, 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 20 year-old male injured his back on ____ while lifting a heavy cement box. He has been treated with light duty and medications.

Requested Service(s)

Bilateral L3-S1 facet injection

Decision

It is determined that there is medical necessity for the bilateral L3-S1 facet injection to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates the diagnosis of facet syndrome has been determined due to signs and symptoms and failure of treatment options such as activity restriction, physical

therapy and anti-inflammatory medication. Facet injections at this time could offer both diagnostic and therapeutic benefit to this patient. If the signs and symptoms are relieved acutely by the local anesthetic effect, the diagnosis of facet syndrome is further supported. Additionally, long-term relief of signs and symptoms could result from the effects of corticosteroid preparations. Therefore, the bilateral L3-S1 facet injections 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,



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

GBS:dm
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 25th day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-1901-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests

Information Submitted by Respondent:

- Carrier's Position