

July 27, 2005

Re: MDR #: M2-05-2020-01 **Injured Employee:**
TWCC#: **DOI:**
IRO Cert. #: 5055 **SS#:**

TRANSMITTED VIA FAX TO:
Texas Workers' Compensation Commission
Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

REQUESTOR:
Richard Francis, MD
Attention: Irene
(713) 383-7500

RESPONDENT:
St. Paul Guardian Ins. Co
c/o Law Office of Patrick Groves
Attention: Dan Flanagan
(512) 347-7870

TREATING DOCTOR:
John Randolph, DC
(713) 451-3392

Dear Ms. ____:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in Orthopedic Surgery and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Texas Workers' Compensation Commission
Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744

FAX (512) 804-4011

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

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 July 27, 2005.

Sincerely,

Gilbert Prud'homme
General Counsel

GP/th

REVIEWER'S REPORT
M2-05-2020-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

From Requestor:

Office note 04/26/04

Operative report 05/13/05

Radiology report 01/29/03

From Respondent:

Correspondence

Designated doctor reviews

From Spine Surgeon:

Office note 04/26/05

Radiology report 04/06/05

Clinical History:

The patient is a 46-year-old female who suffered a work-related injury to her lumbar spine on _____. The patient allegedly slipped and fell, landing on her back. She had a history of previous back

injury from a motor vehicle accident in February of that year, which was treated with medical and chiropractic management. She continued to have chronic pain. An MRI scan was performed of the lumbar spine showing some disc bulges at L3/L4, L4/L5 and L5/S1. She had received some facet injections as well as pain-provocation discogram and surgical fusion at L4/L5 and L5/S1 was recommended by the spine surgeon. The spine surgeon, Dr. Richard Francis, recommended obtaining an MRI scan of the right hip in view of the chronic hip pain and reproduction of pain with motion. This has been denied as medically unnecessary by the insurance company.

Disputed Services:

Repeat MRI of right hip.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that a repeat MRI of the right hip is medically necessary in this case.

Rationale:

The carrier is denying a repeat MRI scan of the right hip. However, the reviewer found no evidence that an MRI scan of the right hip was performed. The spine surgeon's assessment did show a decreased range of motion in the hip as well as classic groin pain with this range of motion, and I believe that an MRI scan may be helpful in evaluating her hip prior to undergoing lumbar fusion surgery. In reviewing the denial requests by all of the treating physicians, they appear to be focusing on the lumbar spine and coccyx and not really the reason Dr. Francis was ordering the MRI scan. His concerns find decreased range of motion, chronic pain, as well as classic pain referred to the groin. The reviewer believes an MRI scan would be reasonable to rule out any abnormalities prior to pursuing surgical treatment of her lumbar spine. This decision is based on Dr. Francis' assessment of decreased range of motion and pain to the groin, which is classic for abnormalities of the hip. The reviewer believes it would be a reasonable workup prior to undergoing the proposed lumbar spine surgery.