



Specialty Independent Review Organization, Inc.

August 3, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-2106-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Osteopathy with a specialty in Orthopedics. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This 51-year-old female was working at school. On ___ there was a child on the floor behind her and she did not know it. She stepped backwards and fell on her left side. Since that time she has had severe low back pain, bilateral hip and leg pain. She has radicular type pain down her right leg to her great toe with a sensation of numbness.

The physical examination reveals: Patient is 5'3" and weighs 280 pounds. Strength and sensation are normal, walk with a slightly flexed posture, and straight leg raise is positive at 60 degrees. The MRI of 12/20/2004 reveals degenerative disc changes at L4-5 and 5-S1, together with facet joint hypertrophy and cyst formation at the L4-5 level.

RECORDS REVIEWED

IMO Letters – 2 with no dates.

Records from Doctor and Facility:

R LeGrand MD Reports – 12/30/2004 to 4/28/2005.

HealthSouth MRI – 12/20/2004.

Records from Carrier:

IMO Letter – 6/1/2005.

P Osborne MD Report – 1/25/2005.

Patient Letter – 5/17/2005.

REQUESTED SERVICE

The requested service is a lumbar myelogram with computerized tomography scan.

DECISION

The reviewer disagrees with the adverse determination.

BASIS FOR THE DECISION

This obese female had traumatic event when she fell backwards on ____, landing on her left buttocks. Since that time she has had radicular symptoms involving the right lower extremity. The MRI revealed facet hypertrophy and a facet cyst at the L4-5 level. Patients can have radicular complaints with mechanical back pain. Mechanical back pain can cause radicular symptoms. Because of the patient's fall and persistence in her complaints, medical/legally the myelogram and post CT scan will either rule in or rule out extrinsic defects affecting the nerve root or dural canal. After this diagnostic test is completed, the definitive plan of care can be determined.

REFERENCES

Renfrew: Atlas of Spine Imaging.

El-Khoury, Bennett & Stanley: Essentials of Musculoskeletal Imaging.

Grossman & Housem: Neuroradiology: The Requisites, 2nd Edition.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) 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: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 4th day of August 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli