



NOTICE OF INDEPENDENT REVIEW DECISION

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October 14, 2005

Amended Letter: October 20, 2005

Requestor

John A. Sazy, MD
ATTN Kristi Songer
431 Omega Dr., Ste 104
Arlington, TX 76014

Respondent

TML Intergovernmental Risk Pool
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
505 W. 12th St.
Austin, TX 78701

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-05-2360-01
IRO Certificate #: IRO4326

The TMF Health Quality Institute has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) 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 1969, 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 patient suffered a lumbar spine injury on ___ in a work related injury as an employee of the _____. She has undergone two surgical procedures and still suffers back pain.

Requested Service(s)

Lumbar myelogram with computed tomography (CT)

Decision

It is determined that the lumbar myelogram with CT is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation does not include any findings suggestive of compressive neuropathy. There are no new physical findings that would suggest that decompression of nerve roots would be considered during any contemplated surgical procedure. Shifting of one of the surgically implanted gages can usually be determined by comparing a series of post operative x-rays. Instability should be evaluated first by flexor extension lateral lumbar spine x-rays. Therefore, it is determined that there is no documented indication to suggest that a lumbar myelogram with CT follow-up is medically necessary.

This decision by the IRO is deemed to be a DWC decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 Department of Insurance, Division of Workers' Compensation, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

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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, DWC

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 14th day of October 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Used by TMF in Decision

Patient Name: ____

MDR ID #: M2-05-2360-01

Medical record documentation provided:

- **Progress Notes**
- **Peer Review**
- **Diagnostic Tests**
- **Requests**