

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

April 18, 2002

**Re: IRO Case # M2-02-0528-01**

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The \_\_\_ reviewer who reviewed this case has determined that, based on the medical records provided, the requested care is not medically necessary. Therefore, \_\_\_ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

This case involves a 38-year-old male who on \_\_\_ developed pain in his neck and left shoulder while lifting wall boards. Subsequent pains, as late as 2/19/02, developed in his left shoulder, neck, hands, left knee and right knee. An MRI on 8/17/01 showed no significant abnormalities that would account for the patient's discomfort. A 9/25/01 electromyogram was normal as far as suggesting any radiculopathy. Examinations have failed to reveal any neurological deficit to suggest nerve root or spinal cord injury secondary to the event of 4/14/01.

I agree with the carrier's decision to deny this patient the requested myelographic evaluation with CT scanning of the cervical spine. The primary reason is that myelography is a very uncomfortable procedure at times, and is associated with complications. There is nothing to suggest that findings on the myelogram

would lead to any specific therapeutic measure, such as a surgical procedure, that would take care of the patient's multiple complaints. Myelography should be preserved for circumstances in which the results of the myelogram will potentially lead to some therapeutic benefits, with specific abnormalities looked for. In this case no such circumstances exist since there are multiple complaints which are difficult to relate to any particular area in the cervical spine which would account for their existence.

This medical necessity decision by an Independent Review Organization 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 the decision and has a right to request a hearing. 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 4066, Austin, TX 78704-0012. 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.

Sincerely,

\_\_\_\_\_

President

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I hereby certify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or US Postal Service from the office of the IRO on this \_\_\_\_\_ day of \_\_\_\_\_ 2002.

Signature of IRO Representative:

Printed name of IRO Representative: