

NOTICE OF INDEPENDENT REVIEW DECISION

June 13, 2002

Requestor

Respondent

RE: Injured Worker:
MDR Tracking #: M2-02-0643-01
IRO Certificate #: 4326

The ___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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 ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ 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 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 58 year old male sustained an injury to his cervical spine on ___ when he was holding onto a tank and holding up the steel chain that fell on his right arm. The patient has undergone repair of his rotator cuff injury; however, he still has severe neck pain on the right side with tightness in his trapezius on the right side. An MRI revealed multi level degenerative disease at C3-C4 with posterior ridging and spurring on the right with foraminal stenosis. He also has mild right foraminal stenosis at C5-C6. As part of the patient's work-up, the treating physician has recommended that the patient undergo an upper extremity EMG/NCV with cervical myelogram.

Requested Service(s)

Upper extremity EMG/NCV with cervical myelogram.

Decision

It is determined that the EMG/NCV with cervical myelogram is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical work-up required to make a decision regarding this patient's condition is not yet completed. No decision regarding further surgical intervention can be reached without completing the patient's evaluation. Completing the patient's evaluation requires the patient to undergo a myelogram and an EMG/NCV of the arm. Therefore, it is determined that the cervical myelogram and the EMG/NCV of the upper extremity are diagnostic tools and should be an integral part of this patient's treatment plan.

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) days of your receipt of this decision (20 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) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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 (Commission Rule 133.308 (t)(2)).

Sincerely,

cc:

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 _____ day of _____ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: