

## NOTICE OF INDEPENDENT REVIEW DECISION

September 11, 2002

RE: MDR Tracking #: M2-02-0689-01  
IRO Certificate #: 4326

\_\_\_ 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 family practice 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 52 year old female sustained a work related injury on \_\_\_ when she was reaching forward, struck her desk and fell backwards onto a chair that flipped on top of her. The patient injured her neck and upper limb. An MRI revealed a level C7 nerve root impingement secondary to a C6-7 disc protrusion. A nerve conduction velocity study indicated C5-6 radicular changes. A CT myelogram revealed spondylosis at C3-4, C5-6 and C6-7 with disc bulging at each level. An MRI of the left shoulder on 02/05/99 indicated a full thickness tear of the distal supraspinatus tendon in her left shoulder. The patient subsequently underwent a left rotator cuff surgery/release. The patient is being evaluated for increased neck pain in her left side with paresthesias to her left hand in C8 distribution.

### Requested Service(s)

Cervical MRI

### Decision

It is determined that a cervical MRI is medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

This patient has known cervical disc bulging at levels C3, C4, C4-5, and C6-7. A physical examination indicates that the patient may now have involvement with adjacent discs. An MRI of the cervical spine is a medically indicated diagnostic tool and should be an integral part of this patient's treatment plan. Therefore, a cervical MRI is medically necessary.

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** (10) 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,