

November 13, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.0698.01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Neurology and Pain Medicine.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

Clinical History:

This female claimant sustained a work-related injury on ___, with x-rays showing a small bone fracture in the neck vertebrae.

Since then, she has had continued difficulty with neck pain, as well as occipital headaches, bilateral cervical radicular symptoms, including pain radiating into both arms, associated with numbness and tingling as well as possible weakness. She has had temporary relief with cervical epidural steroid injections. As of June 2002, she continued to have symptoms most attributable to radiculopathy, with pain, numbness and weakness in the right upper extremity. Physical exam shows slightly decreased strength in the right arm compared to the left, as well as decreased sensory function in the right as compared to the left, and restricted range of motion of the cervical spine.

An MRI of the cervical spine on 06/14/02 revealed multi-level degenerative change, with the most prominent levels being C3-4 where there is a broad-based central disc herniation with cranial extension and some central spinal stenosis. At C4-5 there is a disc herniation that is impinging on the subarachnoid space. At C5-6 there is a broad-based central herniation that is lateralized to the right, with bilateral neuroforaminal stenosis, as well as central spinal stenosis at this level.

Disputed Services:

Left-sided cervical facet injection at four levels.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedures in question are not medically necessary in this case.

Rationale for Decision:

It is clear that this claimant has significant structural disease, a part of which may include a component of facet joint pain. However, this is most likely a minor component of her overall pain condition. It is not likely that treating the facet joints alone will result in symptomatic relief of the patient's overall pain condition.

The patient is clearly describing radicular symptoms and does have examination findings of radicular dysfunction, which is also correlated on the most recent MRI scan of the cervical spine. The most effective treatment options for this patient will be geared more toward decompression of the compressed nerve root and spinal cord. This may be accomplished either conservatively, over time, with physical therapy and appropriate exercise; or, surgical decompression may be an option as well.

Examination and the recent MRI scan of the cervical spine reveal radicular dysfunction. Cervical facet injections on the left side at four levels will not offer significant relief of the patient's overall pain condition. It appears that the most effective treatment options will include treatment geared more toward decompression of the compressed nerve root and spinal canal. This may be accomplished either conservatively, over time, with physical therapy and appropriate exercises, or surgical decompression may be an option, as well.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) 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 Workers' Compensation Commission
P.O. Box 40669
Austin, TX 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.

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 November 11, 2002.

Sincerely,