

## NOTICE OF INDEPENDENT REVIEW DECISION

September 18, 2002

RE: MDR Tracking #: M2-02-1127-01  
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 neurology 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 41 year old male sustained a work related injury on \_\_\_ when she slipped on ice and fell. The patient injured her neck and left shoulder. An MRI performed on 09/01/95 revealed degenerative disc disease with anterior herniation at C5-6 and mild posterior disc bulging at C4-5 and C5-6. She underwent an arthroscopy of the left shoulder on 09/06/96 and a manipulation under anesthesia on 05/09/97. The patient has been treated with multiple visits of physical therapy and multiple series of epidural steroid and trigger point injections. A repeat MRI on 06/30/98 revealed a small left paracentral disk bulge at C5-6 with no significant internal change in appearance from the earlier to the later test. A cervical myelogram and CT scan performed on 04/16/01 revealed no evidence of a rotator cuff repair. The patient now carries a diagnosis of failed spine disease and the treating physician is recommending that the patient undergo a repeat cervical MRI.

### Requested Service(s)

Cervical MRI

### Decision

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

### Rationale/Basis for Decision

Patients may have neck pain without focal complaints, focal findings on examination, or abnormal EMG studies in that central discs and other abnormalities of the midline system can cause pain without nerve root damage. This patient has cervical complaints that are, essentially, non-focal and her physical examinations and diagnostic electromyography (EMG) studies are normal. However, given the chronicity of her complaints, associated with cervical spondylosis, a repeat cervical MRI is appropriate. A repeat study, aimed at evaluating the patient's complaints in a domain (neck) in which she has radiographic substantiated disease, is an appropriate request. Therefore, the cervical MRI is medically necessary.

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

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### **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,