

## NOTICE OF INDEPENDENT REVIEW DECISION

November 27, 2002

RE: MDR Tracking #: M2-03-0189-01  
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 anesthesiology 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 40 year old male sustained a work-related cervical spine injury on \_\_\_ as a result of an auto accident. Surgical evaluation at that time revealed no lesions correctable by surgical intervention. The patient has been receiving conservative treatment, however continues to complain of neck pain radiating to the right shoulder. The history and physical, dated 05/22/02, indicated a diagnosis of mechanical cervicalgia, rule out cervical facet syndrome versus degeneration. The attending physician recommended a left cervical MRI.

### Requested Service(s)

Left cervical MRI

### Decision

It has been determined that the left cervical MRI is medically necessary.

### Rationale/Basis for Decision

According to an orthopedic surgeon's correspondence, dated 11/04/96, an MRI scan in September 1996 revealed a herniated cervical disc. The surgeon also indicated that the patient's impairment rating was based on the specific disorder of "herniated disc". As it is possible to re-herniate a disc, and in view of the patient not having radicular symptoms to the scapular, the MRI is an appropriate diagnostic tool to determine diagnosis and treatment. Therefore, the left 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,