

NOTICE OF INDEPENDENT REVIEW DECISION

April 18, 2003

RE: MDR Tracking #: M2-03-0458-01
IRO Certificate #: IRO4326

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 patient sustained a work-related injury on ___ when a 500-pound machine press fell on his right upper extremity pulling him to the ground causing him posterior neck pain and bilateral shoulder pain. The patient underwent arthroscopic surgery of the right shoulder with rotator cuff repair, followed by debridement of an infected wound, followed by physical therapy.

Requested Service(s)

Cervical discogram with CT scan

Decision

It is determined that the cervical discogram with CT scan is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

It was noted that the patient has right upper pain. It is in “approximately C-6 dermatome to the forearm” and then “in approximate C-7 dermatome in the fingers.” It is also noted that the upper extremity is in an approximate “C-6 dermatome in the level of the elbow”. An electromyographic report revealed a right carpal tunnel syndrome, as well as “ulnar nerve compression.” The physical examination revealed “extremely limited range of motion in the upper extremity”. The patient also was noted to be carrying the right shoulder and trapezius muscles lower than the left side. He had strength deficits of the right fingers, wrists, biceps and triceps. No significant muscle atrophy was noted despite the fact that the patient “was essentially unable to lift his arm above his right shoulder”. The patient also had reproduction of neck and right upper extremity pain with both right and left neck rotation.

The MRI performed on 08/16/02 indicated a left posterolateral C4-5 disc herniation with multi level disc degeneration change and uncovertebral spur at C4-5 on the right in addition to C6-7.

It has been recommended that the patient undergo a cervical discogram at the C4-5, C5-6, and C6-7 levels in order to locate the pain generator. Based on the documented neck and shoulder problems, this would be the appropriate procedure at this time.

Therefore, the cervical discogram with CT scan 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,

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 21st day of April 2003.