

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 18, 2003

RE: MDR Tracking #: M2-03-1322-01
IRO Certificate #: 5242

___ 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon 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

The claimant is status post C5/6 anterior cervical discectomy/fusion in 1999 with history of chronic neck and back pain.

Requested Service(s)

Cervical and lumbar myelograms with CT scan.

Decision

I agree with the insurance carrier that the requested interventions are not medically necessary.

Rationale/Basis for Decision

In order to justify the medical necessity of a myelogram/CT, there should be some objective documentation. There is no documentation of significant neurocompressive lesion. There is no documentation of EMG/NCV study indicating significant radiculopathy. The neurological deficits in the hand are secondary to carpal tunnel syndrome, not nerve root compression. Finally, the office note states that the claimant had undergone a gastric bypass just two months previously.

If there are additional objective findings, not provided in the documentation, which would suggest that operation is under consideration, in the absence of a significantly acutely worsening problem, operation should be postponed until the full benefits of the gastric bypass procedure are known, both to decrease the anesthesia risk and to see if decreased weight will ameliorate the current symptoms.

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** (ten) 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)).

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