

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 10, 2003

Re: IRO Case # M2-03-1464

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 45-year-old female who on ___ developed right shoulder pain while throwing out trash. She was taken to the ER, where x-rays revealed no shoulder problem of an acute nature. Subsequent treatment included medication and rest. Nevertheless, the pain persisted. It was noted initially that the pain increased with shoulder movement. An MRI of the cervical spine on 1/6/03 showed some changes at C5-6 and C6-7 without anything distinctly significant from a surgical standpoint, such as evidence of nerve root compression.

Requested Service(s)

Cervical laminectomy

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

The only report of possible C7 nerve root injury in the material presented for this review was of weakness in the right triceps muscle. Neither the MRI nor the CT scan show enough evidence suggestive of that area of the neck being the source of difficulty. More testing such as EMG that might reveal “subclinical” findings of C7 nerve root compression would be helpful in reaching conclusions regarding the exact nature of the patient’s pathology. Also, examination with findings of a sensory deficit in the index finger and a diminished triceps reflex could lend support to a surgical procedure directed to that particular area. At the present time in the records provided for review, however, no such findings were present.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission 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** (ten) days of your receipt of this decision (28 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 a hearing should be sent to:
Chief Clerk of Proceedings, Texas Worker’s Compensation Commission, P O Box 40669, Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this 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 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 12th day of August 2003.