

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 9, 2004

MDR Tracking #: M2-04-0860-01
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 reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. 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

The claimant is a 47 year old arson inspector with city of ___ injured on ___ during a hand to hand combat drill. She subsequently underwent cervical fusion C4-C7 with anterior plating on 4-30-98. It was noted she had congenital cervical stenosis on preoperative studies. She did well for about one year post operative. She began developing recurring symptoms complaining of intrascapular and right shoulder pain, and some weakness in the upper extremities. The claimant was seen by ___ neurosurgeon on 11/17/03. He noted no atrophy, reflexes were equal in upper extremities slightly hyperactive in lower extremities. Sensation was intact in all extremities, muscle strength was intact. Noted normal gait. There was a history of some urinary urgency, no loss of bowel control. Cervical x-ray including flexion extension views revealed fusion appeared solid.”

Requested Service(s)

Cervical MRI

Decision

I agree with carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

The claimant has normal strength and sensation in her extremities. The MRI will probably not be very helpful because of artifact from plate. I would suggest advising her that if she experiences any loss of bowel control or loss of bladder control or increased paresthesias or weakness in

extremities she should seek medical treatment. She needs to be evaluated at least annually to monitor her condition. If further diagnostic studies are contemplated, I would suggest consultation with a fellowship trained neuroradiologist.”

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) calendar 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.