

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 2, 2004

MDR Tracking #: M2-04-0904-01

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 date of injury is ____. Surgery was performed on 2/19/99 discectomy and fusion C5-6 and was unsuccessful. There are continued complaints of neck pain with numbness in upper extremities. The claimant also has a history of carpal tunnel surgery on the right that was not successful. Symptoms have persisted since surgery with no significant change. Two MRIs since surgery exhibit no changes that represent significant difference in findings.

Requested Service(s)

Cervical computerized tomography

Decision

I agree with the insurance carrier that the above services are not medically necessary.

Rationale/Basis for Decision

There has been no change of significance in her complaints or physical findings since the surgery five years ago. She has no neurologic deficits on ___ examinations. There is chronic pain with tenderness, mild spasm. She is chronically depressed. There is no difference between her exam on 1/25/99 and 12/18/03. There are no findings at this time, be it changes in symptoms or physical findings, including neurological deficits, that would justify the medical necessity of computerized tomography.

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.

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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 5 th day of April 2004.
--