

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0975-01

March 29, 2004
IRO Certificate# 5259

An independent review of the above-referenced case has been completed by a medical physician board certified in neurology. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

A 38-year-old male who reported an injury at work on ___ when he injured his neck. There is an extremely complex, convoluted, serpentine history as outlined by ___ his peer review report of 10/10/03. According to ___ summation, however, the patient has continued to have pain in the neck with tingling in the left first, second and third digits (thumb, index, and middle fingers). A small central disc protrusion at C6-7 was delineated on cervical myelogram with post myelography CT scanning. The left C7 nerve root sleeve was "under filled on the myelogram but no disc protrusion was demonstrated on CT to correlate with this finding." EMG report revealed a left C6, C7, and C8 radiculopathy. The patient has continued to have intractable pain.

REQUESTED SERVICE (S)

Cervical discogram with CT scan.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

1. The patient has shown left triceps (C7) weakness on examination.
2. EMG has apparently been compatible with left C6, C7 and C8 radiculopathy.
3. ___ performed the cervical myelogram with post myelogram CT at the request of ___ (the insurance carrier review physician after their telephone conference of 9/3/03) which disclosed the positive findings mentioned above and which correlate with the above listed findings.
4. Concur with ___ statement in his report of 10/10/03 on page 10, the last paragraph that most likely the injury of ___ “probably resulted in a cervical radiculopathy.”
5. Taken all together, all of this evidence strongly points toward a possible left C7 radiculopathy and further investigation needs to be done to ascertain whether this is indeed a likely pain generator for this patient.
6. Concur with ___ statement in his “to whom it may concern” letter of 1/22/04 that cervical discograms are rarely useful but on this occasion this does indeed seem to be indicated.

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 (20 Tex. Admin. Code 142.5©)

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 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the 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 carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 29th day of March 2004.