

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 4, 2004

MDR Tracking #: M2-04-1607-01

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 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.

Records Provided for Review:

- List of disputed services
- Pre-authorization decision by ___
- Letter of Appeal, ___
- Appeal decision
- Carrier position letter
- Peer Review Analysis-Liberty Mutual X 2
- IME, ___.
- Addendum, ___
- IRO Paperwork
- Office notes, ___
- Electrodiagnostic studies

Clinical History

On 5/25/04, ___, neurosurgeon, noted the patient is status post C4-5 anterior cervical disc fusion on ___. The patient continued to have left C4-5 foraminal stenosis and underwent a C4-5 foraminotomy, posterior cervical laminectomy and nerve root decompression on 3/21/01. She is also status post left ulnar transposition on 8/8/00. Her neck pain seemed to be progressively getting worse with 8/10 pain and radiation of pain from her neck to her left arm and fingers.

On 3/6/04, EMG/NCV studies showed bilateral carpal tunnel syndrome and possible left T1 radiculopathy. On 12/29/03, CT scan of the cervical spine showed 1 mm central protrusion at C6-7 with a solid fusion at C4-5 and excellent decompression of the neuro foramen at C4-5.

___ felt the patient to have exacerbation of neck pain and recommended cervical and trapezial trigger point injections with a request for cervical myelogram. The additional peer review by ___ is available for review. ___ felt that the patient is not a candidate for CT/myelogram.

Requested Service(s)

Please review and address the medical necessity of cervical myelogram and post CT scan.

Decision

I disagree with the carrier. The cervical myelogram and post CT scan is medically necessary.

Rationale/Basis for Decision

The patient has had multiple previous surgeries to her cervical spine. She had recent exacerbation of her symptoms with neck pain and radiation to her left upper extremity consistent with cervical radiculopathy. She has had a cervical CT scan showing good solid fusion. However, a cervical myelogram with post myelogram CT scan would better delineate if she has focal sites of neural root compression to correlate with her present symptoms. Given her history of previous cervical spine surgeries, a CT myelogram of the cervical spine would better study the space surrounding her nerve roots and better determine sites of focal neural compression.

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 officer of the IRO on this 7th day of August 2004.