



Specialty Independent Review Organization, Inc.

January 3, 2005

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-0417-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Osteopathy who is board certified in Orthopedics. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This 30-year old patient had a work related injury on _____. The patient works as a construction inspector and while at work, a tractor ran into his car. The patient sustained injuries to his neck and upper back. He had a work restriction of being off work for one month and then returned to work. The patient complains of a tingling sensation in his left arm and a sharp pain down his arm when he sneezes or coughs. The patient has received several epidural injections with temporary relief. Physical therapy has been administered and the neck symptoms have resolved, but the Radicular pain continues. On the 07/22/2004 note, extension of the neck causes the Radicular pain. The motor test to the upper extremity is 5/5. An MRI of 07/08/2004 showed a narrowing of the disc at C5-6 and 6-7. A Myelogram with CT scan on 05/22/2004 showed a narrowing of the disc at C5-6 and 6-7. Both of these diagnostic tests have failed to reveal the cause of the Radicular pain in the upper extremities.

Reviewed Material:

1. Forte – 10 / 15 and 10 / 18 / 2004.
2. Notes of Dr. P, MD – 07 / 22 through 11 / 01 / 2004.
3. Notes of Dr. K, MD – 01 / 19 through 07 / 14 / 2004.
4. PT Notes – 10 / 08 through 11 / 07 / 2004.
5. Epidural Report: 08 / 20 / 2004.
6. Myelogram with CT scan: 05 / 22 / 2004.
7. MRI – 07 / 08 / 2004.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of outpatient cervical provocative discogram with post CT.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states that a discogram with a follow up CT scan is recommended based upon the reference in *ORTHOPEDIC DECISION MAKING* by Bucholz. The CT scan and the MRI do not show the status of the annulus as a cause for discomfort. With the Radicular symptoms aggravated by coughing, sneezing, and extension of the neck, together with questionable MRI and Myelogram tests, the diagnosis is still uncertain.

References:

1. Rothman – THE SPINE, 4th Edition
2. Campbell's OPERATIVE ORTHOPEDICS, 10th Edition
3. Bucholz, ORTHOPEDIC DECISION MAKING, 2nd Edition

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

____, CEO

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 17787, Austin, TX 78744. The fax number is 512-804-4011. 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, per TWCC rule 133.308(u)(2).

Sincerely,

____, CEO

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant’s representative) and the TWCC via facsimile, U.S. Postal Service or both on this ____4th _____ day of ____January_____, 2005 __

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: