

## NOTICE OF INDEPENDENT REVIEW DECISION

November 20, 2002

RE: MDR Tracking #: M2-03-0192-01-SS  
IRO Certificate #: 4326

\_\_\_ 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 a \_\_\_ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. 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

This 52 year old male sustained a work related injury on \_\_\_ when he fell from the rear of an 18 wheel trailer landing on his left side. The patient initially complained of neck and low back pain in addition to left leg pain. Initial x-rays following the accident revealed a fracture of his left wrist as well as a fracture of his left fifth rib. An MRI of the cervical spine performed on 06/17/02 revealed the following:

1. Spondylosis with right-sided foraminal stenosis with overlying bulging at C3-4.
2. Left paracentral posterior protrusion of the disc at C4-C5.
3. Spondylitic change with spondylitic posterior protruded disc at C5-6 and C6-7 with foraminal stenosis bilaterally.
4. Mild degenerative compression of the superior anterior end plate of the vertebral body of C-7.

### Requested Service(s)

Anterior cervical interbody fusion with anterior plate and bone graft.

### Decision

It is determined that the anterior cervical interbody fusion with anterior plate and bone graft is not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The medical record documentation does not contain x-ray reports of the cervical spine yet the patient has been diagnosed with cervical strain. There is no mention of any neurological or radicular symptoms into the upper extremities. The physical examination indicates that the cervical spine "has diminished range of motion in all planes secondary to pain. Motor strength and sensation are intact in the upper extremities. Reflexes are symmetrical." There are no electrodiagnostic studies in the medical record documentation. The patient has been treated with non-operative treatment including epidural steroid injections and there is no indication that the patient would benefit from surgical intervention. Therefore, it is determined that the anterior cervical interbody fusion with anterior plate and bone graft is not medically necessary to treat this patient's condition.

This decision by the IRO is deemed to be a TWCC decision and order.

-----

### **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** (10) days of your receipt of this decision (20 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) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,