

NOTICE OF INDEPENDENT REVIEW DECISION

February 18, 2003

RE: MDR Tracking #: M2-03-0377-01
IRO Certificate #: IRO 4326

The ___ 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 40 year old male sustained a work-related injury on ___ when he injured his lower back. An MRI revealed abnormalities at L5-S1 and a discogram was performed. The discogram confirmed concordant pain at the L5-S1 levels only with the other levels normal. There was also a left-sided annular tear at the L5-S1 level. The patient underwent an Intradiscal Electrothermal annuloplasty on 02/08/02. An MRI of the cervical spine revealed bulging at C4-5 and radiculopathy at C-7. The treating physician has recommended that the patient undergo an anterior cervical discectomy/fusion at C4-5.

Requested Service(s)

Anterior cervical discectomy/fusion at C4-5.

Decision

It is determined that the anterior cervical discectomy/fusion at C4-5 is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation fails to indicate that the patient's primary neck and left upper extremity symptoms are related to the C4-5 level. Documentation indicates that there are a number of disc abnormalities. One review of the MRI is said to show findings of disc herniation at C5-6. The electromyography reported C7 radiculopathy (left worse than right). One examination of the cervical spine MRI was also reported to reveal "C6-7 posterior disc herniation more to the left pericentric posteriorly impinging on the thecal sac with borderline foraminal stenosis on the left...". These reports coupled with finding of altered sensation in the middle finger, triceps weakness, and a loss of the triceps reflex, point to a lower level as the source of the problem rather than C4-5. Therefore, the anterior cervical discectomy/fusion at C4-5 is not necessary.

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,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

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 18 th day of February 2003.
