

July 7, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0406-01-SS
IRO #: 5251

___ 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 ___ 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurological Surgery. The ___ 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 ___ 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

___ is a 38-year-old woman who has neck pain, headache and left upper extremity pain consequent to a ___ work-related injury. An MRI revealed a disc herniation at C5/6. On a 2/14/02 MRI there was determined to be "a small midline disc herniation." This was more prominent than on a study in May of 2001. There were also findings of "a mildly bulging annulus at the level of C4/5." This did not show stenosis at the lateral level. Additionally, the 2/14/02 MRI report remarked that there was no stenosis at the level of C5/6. Her EMG/NCV study was reportedly within normal limits. She additionally has some right upper extremity radiating symptoms. Physical therapy has failed to resolve the syndrome.

REQUESTED SERVICE

Anterior Cervical Disc Fusion is requested for this patient at the levels of C4/5 and C5/6.

DECISION

The reviewer both agrees and disagrees with the prior adverse determination.

The anterior cervical discectomy and fusion is warranted at the level of C5/6, but not at the level of C4/5.

BASIS FOR THE DECISION

Treatment guidelines and care standards would indicate that it is neither prudent nor necessary to excise and fuse a bulging disc level without evidence of clear-cut neuroradiographic impingement, electrophysiologic correlation, or positive discogram study with reference to the bulging disc level. Therefore at the present time the C5/6 cervical discectomy and fusion is felt to be warranted and medically necessary, although the cervical discectomy and fusion at the level of C4/5 is not felt to be medically necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

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

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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 40669, Austin, TX 78704-0012. 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(t)(2).

<p>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 7th day of July 2003.</p>
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