

January 7, 2003

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

MDR Tracking #: M2-03-0428-01
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 Orthopedic 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 42-year-old woman who sustained a work-related injury on or about ___. Records indicate that she was employed for the city of ___ as a receptionist in the ___ when she fell from a chair, landing on her knees, twisting her neck and her back. She then experienced neck and back pain. It is noted had a prior work-related neck injury. She injured herself in ___ when she fell from a ladder and hit her head and neck. She was treated conservatively for this.

___ did come under the care of ___ who remained her treating physician. She has had extensive treatment to include physical therapy, multiple injections into her neck and back, work hardening, etc. An FCE demonstrated multiple inconsistencies. The patient was deemed to reach MMI on March 1, 2000, and was assigned a twelve percent whole person impairment, which was later revised.

She has undergone a lumbar laminectomy and fusion from L5 to S1 with spinal instrumentation and allograft by ___ on February 13, 2001. Records indicate that surgery gave her a “slight relief” in terms of back pain.

___ had a cervical myelogram on November 8, 2001, which demonstrated posterior disc protrusion and moderate central spinal stenosis from C3-C7. It is also noted that a MRI on August 22, 2001 found that the patient has “congenital central canal stenosis of her spine.”

She has been complaining of neck pain intermittently for several years. She has seen multiple physiatrists and psychologists. She has been diagnosed with atypical depression as well as chronic pain syndrome. ___ continues to see ___ and complains of neck pain and bilateral arm pain, left greater than right. She has significant weakness in her left hand. Reflexes are depressed at C5-6.

Physical examination of this patient demonstrates that she is morbidly obese at 5’3” and weighing in excess of 300 pounds. Her medical record is full of multiple inconsistencies to include Waddell’s symptoms, pain out of proportion to physical findings, and poor relief of pain after lumbar surgery.

REQUESTED SERVICE

She was recommended an anterior cervical discectomy and fusion from C3 through C7.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

___ sustained soft tissue injuries to her cervical spine to include a cervical strain/sprain. It is noted that this patient’s symptoms are consistent with gradual development of cervical spondylosis with cervical disc disease with bilateral upper extremity radiculitis/radiculopathy.

The reviewer finds that the patient would not likely benefit from the requested surgery. She has had significant surgery on the lumbar spine for a similar condition, with minimal to no benefit. Also, this patient has chronic pain syndrome, morbid obesity, chronic pain behavior and depression, all of which are significantly detrimental to a successful cervical discectomy and fusion.

___ 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).