

March 10, 2003

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

MDR Tracking #: M2-03-0577-01-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 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 46-year-old gentleman employed by the ___. On ___, he was driving his truck over rough terrain and hit large bumps, causing him to be jerked around causing injury to his neck. He noted pain in the neck with some muscle spasm and radiation of pain down the left arm into the left thumb and radial side of the hand. The pain became severe and it was refractory to conservative treatment. He noticed a great accentuation of the pain when he coughed or sneezed. He did not have any lower extremity symptoms or symptoms of bowel or bladder control problems. He was treated with medication for pain, muscle spasms and anti-inflammatory medication. He had oral steroids. He wore a cervical collar. He did not get any relief from any of those conservative measures. ___ received physical therapy and tried exercises that only made it worse. The patient was found to have definite signs of nerve root compression involving the left upper extremity. He was found to have mild atrophy in the left brachioradialis and triceps muscle. The numbness in the thumb and radial side of the hand persisted. There was a decrease in the deep tendon reflexes involving the left upper extremity. The patient had MRI study,

which demonstrated some degenerative changes in his cervical spine with C4/5 disc bulging with pressure on the spinal cord. There was some spinal stenosis reported at C4/5 and some minimal foraminal stenosis at that level.

At C5/6 there was some spinal canal stenosis reported and some left foraminal stenosis. He also had degenerative changes at C6/7 with disc bulging at that level but not as severe as the other two levels. The patient had a myelogram CT scan on 11/1/01 and it demonstrated flattening of the cord and the thecal sac at C3/4. At C5/6 there was felt to be some nerve root pressure and at C6/7 there was only disc bulging noted.

REQUESTED SERVICE

Anterior cervical fusion with instrumentation is requested for ____.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The records, though brief, do document specific evidence of radiculopathy involving the left upper extremity, which is due to disc herniation at C4/5 and C5/6. The ____ reviewer finds that surgery is indicated for this patient.

With regards to the rationale for this decision, the patient has had continuous pain for many months and has been noted by a neurosurgeon to have decreased motor strength in the left biceps muscle, brachioradialis muscle and triceps muscle. He has also been noted to have diminished deep tendon reflexes in the left upper arm and the neurosurgeon says that there is a flattening of the spinal cord on the CT myelogram. He also is having numbness in the radial side of the left hand and in his left thumb, which would go along with a C5/6 nerve root pressure. The request for a two-level anterior discectomy at C4/5 and C5/6 is felt to be valid, and the reviewer finds that it is an indicated surgical procedure.

____ 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).

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 10th day of March, 2003.