

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

April 21, 2003

**Re: IRO Case # M2-03-0701**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 42-year-old female who on \_\_\_ was helping move a heavy desk and developed neck pain along with right hand pain with numbness and tingling in her right elbow and hand. The pain persisted. An MRI evaluation on 7/8/02 showed a probably surgically significant C4-5 disk herniation with what is described as spinal cord indentation. The patient has had conservative measures, including epidural steroid injections, without significant benefit. The patient has now developed right and central headache and pain in the periscapular region, mainly to the right side. There is no neurologic deficit. Discography was requested, but denied.

Requested Service

ACFD atC4-5 – cervical fusion

Decision

I disagree with the carrier's decision to deny the requested procedure.

Rationale

The patient's pain distribution, including even the headache, is compatible with the findings on the MRI of a C4-5 disk rupture. This is true despite the lack of neurologic findings. Discography would not change the surgical approach to this patient's problem. The patient has had nine months of continuous difficulties despite considerable conservative attempts to relieve her pain, and the proposed surgical procedure is justified. In addition to relieving symptoms, the requested procedure could possibly diminish the risk of significant spinal cord injury secondary to future trauma.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission 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** (ten) days of your receipt of this decision (28 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 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 (Commission Rule 133.308(t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 22<sup>nd</sup> day of April 2003.