

June 17, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-03-1079-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. This physician is a board certified neurosurgeon. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 63 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she fell when attempting to sit in a chair. The patient landed directly on her buttock falling back and hitting her head on the ground. The patient was evaluated in the emergency room where X-Rays of the neck and coccyx were taken. The diagnoses for this patient included cervical strain, lumbosacral strain, contusion coccyx and contusion right hip. The patient was initially treated with physical therapy but reported no improvement.

### Requested Services

ACDF C4-5, 5-6, 6-7, BB, Plt.

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 63 year-old female who sustained a work related injury to her neck on \_\_\_. The \_\_\_ physician reviewer also noted that the diagnoses for this patient included cervical strain, lumbosacral strain, contusion coccyx and contusion right hip. The \_\_\_ physician reviewer further noted that treatment for this patient's condition has included physical therapy. The \_\_\_ physician reviewer indicated that an ACDF at the C4-5, 5-6, 6-7, BB, Plt is requested for further treatment of this patient's condition. The \_\_\_ physician reviewer explained that there is no reasonable rationale offered supporting a

multilevel anterior cervical discectomy and fusion. Therefore, the \_\_\_ physician consultant concluded that the requested ACDF C4-5, 5-6, 6-7, BB, Plt is not medically necessary to treat this patient's condition at this time.

This decision 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 (ten)** 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 a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 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,

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 17<sup>th</sup> day of June 2003.