

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 28, 2003

RE: MDR Tracking #: M2-03-1414-01-ss

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon reviewer has signed a certification statement stating 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 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 this case.

Clinical History

Claimant is a 34-year-old female with chronic neck pain reportedly related to a compensable injury that occurred in ___. An MRI report of 12/26/01 indicates mild facet arthrosis. The reviewer suggested a brain MRI due to patient symptoms which include left leg numbness as well as bilateral hand symptoms. An EMG nerve conduction study report of February 27, 2001, indicates the only abnormality of EMG consisted of increased insertional activity in the left mid-cervical paraspinal muscles and the impression was left mid-cervical nerve root impingement, either C5 or C6 levels. Clinical and radiographic correlation was recommended.

Requested Service(s)

Anterior cervical discectomy and fusion.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

There is no clear correlation between the nonspecific EMG findings in the report of February 27, 2001, with radiographic findings. A post-myelogram CT study has indicated no evidence of central or foraminal stenosis at any cervical level.

Claimant exhibits a normal neurologic exam. There has been no specific identification of pain generator site. A brain MRI was suggested and has not been performed. Claimant has exhibited upper and lower nerve symptoms. Generally, mild EMG nerve conduction study findings are followed up by a repeat study, particularly when surgical intervention is anticipated.

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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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)).

This decision by the IRO is deemed to be a TWCC decision and order.