

MDR Tracking Number: M2-03-1503-01
IRO Certificate# 5259

August 5, 2003

An independent review of the above-referenced case has been completed by a neurosurgeon physician. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

The patient is a 55 y/o female who sustained an injury at work on ___ with subsequent neck and left shoulder and arm pain. The subacromial space was injected without significant benefit. MRI 1-2-01 showed disc herniations at right C5-6, right C6-7 and left C7-T1. Left C8 SNRB produced resolution of pain and patient underwent ACDF C7-T1 on 4-19-01 with temporary relief of symptoms. She now has neck and shoulder pain. She has undergone C6-7 SNRB's which provided some pain relief and C7-T1 SNRB's which also provided pain relief. Extension of the fusion at C7-T1 to C6-7 has been proposed with plating.

REQUESTED SERVICE (S)

Anterior cervical disectomy C6-7 with plate, removal of C7-T1 plate

DECISION

The request for instrumented cervical fusion is recommended as a treatment option consistent with standards in spinal surgery.

RATIONALE/BASIS FOR DECISION

This patient has degenerative disc disease at multiple levels. She has undergone a previous fusion at C7-T1 and now has symptoms presumably referable at least in part to the C6-7 level.

It is unlikely that this is the sole source of her pain based on the data from the selective nerve root blocks. Based on MRI there is a disc herniation at C6-7, which, if fused, could result in some reduction of her pain. In addition, there is persistent foraminal stenosis secondary to facet hypertrophy at C7-T1, which will likely require surgical intervention.

CERTIFICATION OF INDEPENDENCE OF REVIEWER

I had no previous knowledge of this case prior to it being assigned to me for review. I have no business or personal relationship with any of the physicians or other parties who have provided care or advice regarding this case. I do not have admitting privileges or an ownership interest in the health care facilities where care was provided or is recommended to be provided. I am not a member of the board or advisor to the board of directors or any of the officers at any of the facilities. I do not have a contract with or an ownership interest in the utilization review agent, the insurer, the HMO, other managed care entity, payer or any other party to this case. I am not a member of the board or advisor to the board of directors or an officer for any of the above referenced entities. I have performed this review without bias for or against the utilization review agent, the insurer, HMO, other managed care entity, payer or any other party to this case.

As the reviewer of this independent review case, I do hereby certify that all of the above statements are, to the best of my knowledge and belief; true and correct to the extent they are applicable to this case and my relationships. I understand that a false certification is subject to penalty under applicable law.

I hereby further attest that I remain active in my health care practice and that I am currently licensed, registered, or certified, as applicable, and in good standing.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

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) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 5th day of August 2003.