

MDR Tracking Number: M2-03-1574-01  
IRO Certificate # 5259

August 20, 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 43 year old male who began having neck pain, shoulder pain, and arm pain after a work related injury in \_\_\_\_\_. Past medical history is significant for two left shoulder surgeries. He reports that his symptoms are exacerbated with coughing and sneezing and he has developed weakness in his left arm. MRI 8/27/02 was of poor quality but showed C6-7 spondylosis with some foraminal narrowing. CT myelogram 1/6/03 was unsuccessful. Neurophysiological testing revealed C5-7 radiculopathies. Pain was not relieved with two epidural steroid injections and physical therapy. Anterior cervical disectomy and fusion at C6-7 was recommended.

#### REQUESTED SERVICE (S)

ACDF C6-7

#### DECISION

The request for ACDF C6-7 is recommended as a treatment option.

#### RATIONALE/BASIS FOR DECISION

This patient has symptoms of cervical radiculopathy and neck pain exacerbated with valsalva maneuvers. MRI shows spondylosis at C6-7 while EMG shows evidence of C5-7 radiculopathies. The patient's symptoms do not clearly implicate this level as the cause of his problem however sensory and motor innervation is highly variable.

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 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 21<sup>st</sup> day of August 2003.