

August 28, 2003

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TWCC Medical Dispute Resolution
MS-48
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Austin, TX 78744-1609

MDR Tracking #: M2-03-1622-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Osteopathy with a specialty and board certification in Neurological Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ suffered a work-related injury that resulted in right arm pain and numbness, for which she is seeing several different physicians. She has had epidural steroids, a selective nerve block at the C6 level and an MRI of her right shoulder that showed a supraspinatus tendon tear involving the anterior fibers. She had an MRI dated 4/28/03 with the impressions of a suboptimal exam showing a left C6/7 foraminal disc herniation. There is no evidence of any other stenosis or nerve root entrapment or disc herniation. A lumbar myelogram CT scan was performed showing the neuroforamina appeared to fill symmetrically. At 5-6 there was a spondylosis with mild ventral effacement of the thecal sac with no cord compression. The neuroforamina are adequately patent at this level and in a similar fashion at 6-7 there is spondylosis with some mild canal stenosis. Despite adequate conservative treatment, the patient still has right arm pain and numbness.

REQUESTED SERVICE

C5-C7 anterior cervical discectomy and fusion/23 observation is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that the requested procedure should be denied because there is on basis for the requested procedures based on the myelogram, CT scanning and MRI findings. There is no evidence of any nerve root compression that would adequately explain the right-sided arm pain. Therefore, the reviewer sees no benefit in an anterior cervical discectomy for this patient.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to 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 (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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

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

<p>I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 28th day of August 2003.</p>
