

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** September 17, 2003

**RE: MDR Tracking #** M2-03-1664-01  
**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 physician reviewer who is board certified in Orthopedic Surgery and has ADL certification. The Orthopedic Surgeon physician 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**

The claimant has a history of chronic neck pain allegedly due to a work compensable injury that occurred on \_\_\_.

### **Requested Service(s)**

Anterior cervical discectomy with interbody fusion and bone graft.

### **Decision**

I agree with the insurance carrier that the requested intervention is not medically necessary rationale for decision

### **Rationale/Basis for Decision**

Generally, clinical work-up of a neurocompressive lesion includes EMG nerve conduction studies and a myelogram prior to any consideration of surgical decompression for a clinical diagnosis of lumbar radiculopathy. There is no documentation of the electromyogram nerve conduction studies supporting a diagnosis of surgical radiculopathy or corresponding anatomical defect consistent with an isolated neurocompressive lesion that would necessitate anterior discectomy and fusion. MRI of the cervical spine indicates only mild spinal cord abutment of posterior disc protrusions at C4-5, C5-6 and C6-7. A myelographic study indicates minimal to small extradural defects. There is no documentation of significant progression of clinical symptomatology, specifically regarding deterioration and neurological status to suggest a

progressive stenotic lesion that would require surgical decompression. The patient may be a candidate for continued chronic pain management to include oral nonsteroidal and steroidal anti-inflammatory medications, physical therapy, and a trial of epidural steroid injection.

### **YOUR 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.