

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

October 27, 2003

**Re: IRO Case # M2-04-0114-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 48-year-old female who was injured in \_\_\_ when she was loading above her head and developed pain in her neck and right shoulder. Medications, physical therapy and manipulations were not beneficial. An anterior cervical discectomy and fusion at C5-6 was performed in 1994. The patient did well for several months after surgery, but in January 1995, the patient felt more neck pain. This led to a C4-5 anterior cervical discectomy and fusion, after diagnosis by CT myelography and MRI. The patient now has neck pain with arm pain, worse on the right side. Recent x-rays show C3-4 retrolisthesis, and cervical discography suggested probable concordant pain at the C3-4 level.

Requested Service(s)

Cervical myelogram with CT scan

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

There is nothing on examination or x-ray reports to suggest C6-7 as a possible source of the patient's trouble, if the surgeon was considering that that level's contribution might be shown on myelographic evaluation. At the C3-4 level there is concordant pain along with retrolisthesis and hypermobility suggesting instability. Myelographic evaluation will not be of benefit in changing the therapeutic approach, which, if surgical, will be anterior cervical discectomy and fusion at the C3-4 level.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

**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.

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 29<sup>th</sup> day of October 2003.