

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

February 9, 2004

**Re: IRO Case # M2-04-0650**

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 40-year-old female who was injured in \_\_\_ while moving a large person from a bed to a stretcher. She developed neck pain that soon radiated into her right upper extremity, primarily at the shoulder. She was seen at the ER and taken off work. Conservative measures did not relieve her pain. A 5/20/99 MRI of the cervical spine showed small herniated nuclei at the C5-6 and C6-7 levels. No surgically significant spinal cord or nerve pressure was thought to be present.

Physical therapy, epidural steroid injections and trigger point injections were pursued without significant benefit. A 1/25/02 EMG showed right C6 radiculopathy and there was an ulnar nerve finding. Ulnar nerve surgery was performed without significant help to the neck and upper extremity. Discographic evaluation on 8/27/03 showed concordant pain produced at the C5-6 and C6-7 levels, with changes on the CT scan compatible with disk problems that could be associated with pain.

Requested Service(s)

C5-6 and C6-7 anterior diskectomy with allograft fusion procedure

Decision

I disagree with the carrier's decision to deny the requested surgery.

Rationale

There is discographic, MRI, CT findings and EMGs all pointing to the potential of surgery being beneficial in relieving pain, stabilizing the neck and decompressing the nerve roots on the right side at the C5-6 and C6-7 levels. The patient has had extensive physical therapy, epidural steroid injections and trigger point injections as well as many medications, and she continues to have significant discomfort. Although, as usual, there is no guarantee that the proposed procedure will be beneficial, there are enough findings on various tests, plus the patient's continued discomfort to indicate that the proposed procedure is potentially very helpful. It is probable, based on the records provided for this review, that the patient's symptoms have been secondary to the \_\_\_ injury.

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.

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 10<sup>th</sup> day of February 2004.