

March 26, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0897-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. A second opinion consultation note dated 3/1/04 indicated that due to the work related injury sustained on ___, the patient had undergone an anterior cervical fusion as well as having a spinal cord stimulator placed in the lumbar spine. It also indicated that the spinal cord stimulator is non-functioning and that the patient would like it removed. It noted that the patient had been treated conservatively with pain management including injection, medications, and an exercise program for chronic neck pain. It indicated that radiographs of the cervical spine showed a two-level anterior cervical fusion at C5-6 uninstrumented and healed, and that a discreet lucent line is seen indicating and confirming pseudoarthrosis at the C4-5 level. It also indicated that the diagnoses for this patient included pseudoarthrosis, C4-5, with continued neck and trapezial pain without objective neurologic loss, and non-functioning spinal cord stimulator. The recommendation from this second opinion is have the patient's fusion healed to see if this level of pain can be reduced, and removal of the non-functioning spinal cord stimulator.

Requested Services

Posterior cervical fusion/dorsal column stimulator removal

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a patient with a pseudoarthrosis at C4-5 by report and confirmed by an independent medical examiner.

The ___ physician reviewer explained that there are two credible options for treatment of pseudoarthrosis. The ___ physician reviewer indicated that these two options include revision anterior surgery or posterior instrumentation. The ___ physician reviewer explained that posterior instrumentation is appropriate and preferable given the fact that the patient had undergone two previous cervical procedures. The ___ physician reviewer also explained that because the stimulator is not working and considered a foreign body and should be removed. Therefore, the ___ physician consultant concluded that the requested posterior cervical fusion/dorsal column stimulator removal is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

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)** days of your receipt of this decision. (20 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)** 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. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

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

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2))

Sincerely,

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 26th day of March 2004.