NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 26, 2004

RE: MDR Tracking #: M2-04-1069-01-SS
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 reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The 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

This is a 47 year old female teacher with history injury on ___. Bookcase fell when she was attempting to move it and fell across some desks. Originally had chiropractic treatment for right shoulder and cervical pain, was seen for shoulder problem by ___ and MRI indicated possible small supraspinatus tear and acromioclavicular hypertrophy. She was seen by ___ on 12-19-2002 complaining of right shoulder pain and loss of motion with a swelling and burning sensation in the right forearm. She also described general weakness in right arm. She denied any numbness or tingling in the hands. She also complained of right sided low back pain at that time. Physical findings on that visit were all right sided. On 1-14-03 she was seen initially by ___ with low back right shoulder and neck pain. The history states no left arm pain. Pain goes intermittently into the right arm and middle finger. There were no complaints of numbness or weakness in the upper extremities. Physical examination found no weakness in the upper extremities. Reflexes were intact and equal. On 1-30-03 she complained of neck pain radiating down her right arm so severe she could not work. On 2-25-03 it was noted that cervical MRI on 1-17-03 noted disc herniation with nerve root impingement on left, however, most of her symptoms were on the right. At that time, she was complaining of numbness and tingling in the ring and little fingers of the right hand. She would not move her right upper extremity on that visit. She was diagnosed with right upper extremity radiculopathy on that visit. The 2-25 assessment was by ___. On 4-8-03 she was diagnosed with left C8 nerve root contusion and cervical discogenic pain. This is the first reference I saw in the records to left upper extremity symptoms.

On 5-13-03 she was complaining of left C8 symptoms and diagnosis of complex regional pain syndrome was entertained. On 6-24-03 she was referred to ___ in ___. On that visit it was noted by ___ that biceps and triceps reflexes were full and equal. There was full range of motion sensation and strength in the right and left upper extremity. On 7-22-03 it was noted by ___ that she was having some upper extremity pain on the left. On examination she had full range of motion, strength, and sensation in the right and left upper extremity. Diagnosis was right upper extremity sympathetically mediated pain and right cervical nerve root radiculopathy. On 8-19-03 ___ noted she is to have surgery. Again it was noted she had full range of motion, strength, and sensation in both right and left upper extremity. Diagnosis of reflex sympathetic dystrophy left upper was made as well as left cervical nerve root injury with radiculopathy. On 09-30-03 she was protective of her left upper extremity with allodynia, however, she had full range of motion, strength and sensation in both upper extremities according to his exam. On 1-28-04 ___ recommended a three level fusion C4-C6 for cervical disc herniation and cervical radiculopathy.

Requested Service(s)

Anterior cervical decompression and cervical fusion at C4-C6 (3 levels) with EBI plates and bone graft

Decision

I agree with insurance carrier that above service is unnecessary.

Rationale/Basis for Decision

I have been asked to render this decision on the basis of medical necessity only, without consideration of whether of not the current left upper extremity symptoms and findings are related to the compensable work injury. In the records I had available, there is no mention of left upper extremity problem of significance until ___ some ___ months post ___ injury. Findings have been inconsistent regarding level of pathology and physical deficit. The clinical correlation between imaging findings and exam is inconsistent. Most findings indicate C7 or C8 rather than C6 impingement, except for some references by ___. The diagnosis of Reflex Sympathetic Dystrophy has been entertained which is a contraindication to surgery.

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) 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.