

April 28, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

### MDR Tracking #: M2-04-1085-01-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 40 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she injured her neck and shoulder when she attempted to pull a bag off a bag belt. The diagnoses for this patient have included left cervical radiculopathy, spondylosis at C4-5, left C5 radiculopathy by EMG, status post C5-6 and C6-7 ACDF on 2/9/01, chronic pain syndrome, and a 2mm right C3-4 protrusion. Treatment for this patient's condition has included physical therapy, chiropractic care, cortisone injections, trigger point injection, medications, TENS unit, and surgery. The patient underwent a CT myelogram on 2/6/04 that indicated a ventral defect at C4-5 with some spinal cord compression and a 2-3mm C4-5 central and left sided paramedian protrusion with minimal bulging at C3-4. The patient has been recommended for a C4-5 ACDF due to her continued pain. The current diagnoses for this patient include left C5 radiculopathy, central and left sided C4-5 disc protrusion with spinal cord impingment and compression per myelogram, and status post C5-6 and C6-7 ACDF.

#### Requested Services

C4-5 ACDF with external bone growth stimulator.

#### Decision

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

#### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 40 year-old female who sustained a work related injury to her neck and shoulder on \_\_\_. The \_\_\_ physician reviewer also noted that the diagnoses for this patient have included left cervical radiculopathy, spondylosis at C4-5,

left C5 radiculopathy by EMG, status post C5-6 and C6-7 ACDF on 2/9/01, chronic pain syndrome, and a 2mm right C3-4 protrusion. The \_\_\_ physician reviewer further noted that the treatment for this patient's condition has included physical therapy, chiropractic care, cortisone injections, trigger point injections, medications, TENS unit, and surgery. The \_\_\_ physician reviewer indicated that the patient has been referred for a C4-5 ACDF with external bone growth stimulator for further treatment. The \_\_\_ physician reviewer explained that the patient has no clinical indication for requested surgery. The \_\_\_ physician reviewer indicated that the patient has no evidence of foraminal or nerve root impingement. The \_\_\_ physician reviewer also indicated that there is no clinical evidence of either objective evidence of radiculopathy (EMG) or specific radicular involvement. The \_\_\_ physician reviewer explained that there is no established clinical indication for requested surgery. Therefore, the \_\_\_ physician consultant concluded that the requested C4-5 ACDF with external bone growth stimulator is not 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,