

July 2, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-1400-01

___ 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 and is familiar with the condition and treatment options at issue in this appeal. 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 33 year-old male who sustained a work related injury on ___. The patient reported that while at work he was underneath a car doing repairs when he injured his cervical spine. An x-ray of the cervical spine performed on 5/27/03 was reported to have shown a moderate posterior disc space loss at the C5-6 and C6-7 spine with reversal of the usual cervical lordosis. A MRI of the cervical spine performed on 6/18/03 indicated a small central disc bulge at C3-4 measuring under 2mm, a broad based disc bulge at C4-5 and C5-6 measuring 3mm, a lateralizing disc bulge at C6-7 and no focal herniation or central spinal canal stenosis at any level. A CT myelogram performed on 9/9/03 showed a C3-4 soft tissue protrusion, C4-5 soft tissue protrusion with mild flattening of the cord, a C5-6 soft tissue protrusion and endplate osteophyte mildly compressing the cord and a C6-7 protrusion with no cord compression. An EMG/NCV performed on 12/30/03 was reported to have shown suggestive evidence of a right C8-T1 and C5 radiculopathy. The patient has been recommended for an ACDF at the 4/5 and 5/6 level.

Requested Services

ACDF 4/5 and 5/6

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. No documents submitted

Documents Submitted by Respondent:

1. Report of Medical Evaluation 3/2/04

2. Review of medical history and physical exam 3/29/04
3. Pain Center office notes 3/24/04 and 4/2/04
4. Myelogram report 9/9/03
5. MRI report 6/18/03

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 33 year-old male who sustained a work related injury to his back on ____. The ___ physician reviewer also noted that the patient has been recommended for an ACDF at the C4-5 and C5-6 level. The ___ physician reviewer explained that the patient has evidence of C-8 radiculopathy. The ___ physician reviewer also explained that there is no evidence of spinal cord compression or foraminal encroachment indicating the need for the requested surgery. Therefore, the ___ physician consultant concluded that the requested ACDF at the C4-5 and C5-6 levels 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,

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 2nd day of July 2004.