November 29, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0226-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ 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 orthopedic surgery 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 male who sustained a work related injury on ------. The patient reported that while at work he injured his upper back. He is status post a previous upper back injury in 1994 requiring cervical fusion. The current diagnoses for this patient include cervical radiculopathy, cervical strain, thoracic strain, hypertension, and somatic dysfunction of the cranium, cervical, thoracic, ribs and lumbar spine. The current treatment for this patient's condition has included osteopathic manipulation and cervical epidural steroid injections. A cervical CT scan performed on 4/19/04 indicated multiple areas of fusion at cervical levels, and moderated diffuse posterior osteophytic ridging and disc bulging at C3-4 with mild posterior subluxation with canal stenosis and at least mild flattening of the ventral aspect of the cervical spine cord. The patient has been recommended for a cervical fusion above C4-7 due to a 2mm motion of C3-4.

Requested Services

Anterior cervical discectomy and fusion at C3-4 and hardware removal at C4-5.

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

Documents Submitted by Requestor:

1. Initial Consultation 10/28/04
2. Progress Reports 6/3/04 – 10/26/04
3. Letter from Ortho 9/2/04

Documents Submitted by Respondent:

1. Carrier response 10/15/04
2. Appeal/Reconsideration 9/20/04, 9/10/04
3. Progress report 6/3/04
4. Radiology report 6/3/04
5. Operative report 4/19/04.

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 male who sustained a work related injury to his back ------. The ------ physician reviewer also noted that the diagnoses for this patient's condition has included cervical radiculopathy, cervical strain, thoracic strain, hypertension, and somatic dysfunction of the cranium, cervical, thoracic, ribs and lumbar spine. The ------ physician reviewer further noted that the current treatment for this patient's condition includes osteopathyic manipulation and cervical epidural steroid injections and that an anterior cervical discectomy and fusion at C3-4 with hardware removal at C4-5 has been requested for further treatment of this patient's condition. The ------ physician reviewer indicated that the patient has multiple levels of disc degeneration and history of a previous fusion. The ------ physician reviewer noted that the patient complains of neck pain and headaches. The ------ physician reviewer explained that the patient has no neurological findings on physical exam. The ------ physician reviewer also explained that revision neck surgery with fusion does not typically work for neck pain and headaches. The ------ physician reviewer indicated that there is no good literature to support the requested procedure for this patient's diagnosis. Therefore, the ------ physician consultant concluded that the requested anterior cervical discectomy and fusion at C3-4 with hardware removal at the C4-5 level 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,

State Appeals Department

cc: Texas Workers Compensation Commission

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 29th day of November 2004.

Signature of IRO Employee

Name