



# Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799  
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

## NOTICE OF INDEPENDENT REVIEW DECISION

February 1, 2005

### Requestor

Richard R. Francis, MD  
ATTN: Victor Anaya  
2450 Fondren, #220  
Houston, TX 77063

### Respondent

Service Lloyds Insurance Co.  
ATTN: Robert Josey  
P.O. Box 162443  
Austin, TX 78716

RE: Injured Worker:  
MDR Tracking #: M2-05-0585-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 a TMF physician reviewer who is board certified in Anesthesiology, by the American Board of Anesthesiology, Inc. licensed by the Texas State Board of Medical Examiners (TSBME) in 1989, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF 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 TMF 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 35 year-old male injured his neck on \_\_\_ when he was moving antifreeze. He also complained of pain in his right arm and later developed pain in the left arm. He states he has numbness and weakness into his left thumb, index and long fingers. He has been treated with medication, therapy and epidural steroid injections.

### Requested Service(s)

Proposed spinal surgery (anterior cervical decompression and fusion C4-6).

### Decision

It is determined that there is no medical necessity for the proposed spinal surgery (anterior cervical decompression and fusion C4-6) to treat this patient's medical condition.

### Rationale/Basis for Decision

Medical record documentation indicates an improvement in the condition of this patient. The electromyogram/nerve conduction velocity tests dated one year apart show resolution of the original C5 radiculopathy. However, the magnetic resonance imaging finds a broad based bulge at C5-6 with

spondylosis and mild narrowing on the right neuroforamen at C4-5. Additionally, there is conflicting documentation over the source of the patient's strength deficits and the nature of his symptoms. Since the C5 radiculopathy has resolved, the patient's weakness may be related to pain rather than neurological deficit. Therefore, the proposed spinal surgery (anterior cervical decompression and fusion C4-6) is not medically necessary to treat this patient's medical condition.

This decision by the IRO 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) 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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

Director of Medical Assessment

GBS:dm

Attachment

cc: \_\_\_\_\_, Injured Worker  
\_\_\_\_\_, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), 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 1<sup>st</sup> day of February 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M2-05-0585-01**

**Information Submitted by Requestor:**

- Office Notes
- Diagnostic Tests
- Procedures

**Information Submitted by Respondent:**

- Progress Notes
- Diagnostic Tests
- Procedures
- Claims