

April 6, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

IRO CASE NUMBER: M2-05-1131-01
RE: Independent review for ____

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 3.17.05.
- Faxed request for provider records made on 3.22.05.
- The case was assigned to a reviewer on 4.1.05.
- The reviewer rendered a determination on 4.5.05.
- The Notice of Determination was sent on 4.6.05.

The findings of the independent review are as follows:

Summary of Clinical History

Mr. ____ is a 45 year old male, who is employed as a plumber. He is complaining of headaches and neck pain due to a blow to the head.

Questions for Review

Is an anterior cervical discectomy with fusion of C2-C3 with possible posterior approach, followed by an inpatient stay of 2 days medically necessary?

Determination

My determination **upholds** the URA denial.

Clinical Rationale

The rationale is based on the limited information provided for review. It is not at all clear to me that the cause of the patient's symptoms are based on the chronic central canal spinal stenosis as determined by the ossification of the posterior longitudinal ligament in the cervical spine, identified by MRI.

It is clear, however, that the ossification of the posterior longitudinal ligament is chronic. The MRI did not determine any evidence of acute change. Therefore, there is no evidence to establish that the work related injury contributed to the chronic findings of the MRI. There is no evidence of acute associated pathology in the region of C2-3. The physical exam does not establish an acute relationship.

Clinical Criteria, Utilization Guidelines or other material referenced

Generally accepted utilization standards regarding cervical spine discectomy.

The reviewer is a medical doctor certified by the American Board of Orthopedic Surgery. The reviewer is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

Copies of this determination were faxed and mailed to the insurance carrier or URA, the provider, and the patient.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC: Dr. Walter Piskun
Attn: Lisa Guerrero
Fax: 806.358.2662

Old Republic Insurance
Attn: Neal Moreland
Fax: 512.732.2404

[Claimant]