

  
**INDEPENDENT REVIEW INCORPORATED**

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October 12, 2006

Re:    **MDR #:**        **M2 07 0010 01**        **Injured Employee:**    \_\_\_  
      **DWC #:**        \_\_\_                    **DOI:**                    \_\_\_  
      **IRO Cert. #:** **5340**                **SS#:**                    \_\_\_

**TRANSMITTED VIA FAX TO:**  
**TDI, Division of Workers' Compensation**  
Attention:  
Medical Dispute Resolution  
Fax: (512) 804-4868

**RESPONDENT:**                    **American Home Assurance**

**TREATING DOCTOR:**    **John Sazy, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in orthopedic surgery and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

### Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 October 12, 2006.

Sincerely,



Jeff Cunningham, DC  
Office Manager

**REVIEWER'S REPORT  
M2 07 0010 01**

MEDICAL INFORMATION REVIEWED:

1. DWC assignment
2. Notification of IRO assignment
3. Medical dispute resolution request/response
4. Table of disputed services
5. SRS denial letter
6. Preauthorization request, Dr. John Sazy
7. Request for reconsideration letter, Dr. John Sazy, dated 08/04/06
8. Requestor's records
9. Carrier's records

BRIEF CLINICAL HISTORY:

The injured worker is a 51-year-old male who has chronic herniated nucleus pulposus at the C6/C7 level and a C5/C6 due to work-related injury. The patient has failed conservative management and has positive EMG and MRI scan findings. C5/C6 and C6/C7 anterior discectomy and fusion has been denied as medically unnecessary.

DISPUTED SERVICES:

Anterior cervical discectomy and fusion at C5/C6 and C6/C7 with spinal monitoring has been denied as medically unnecessary.

DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:

The patient's insurance company denials have incorrectly or incompletely reviewed the records, as the patient has chronic cervical herniated discs and pain with an associated neurocompressive lesion that requires surgical decompression and stabilization, the above-mentioned requested procedures indicated for this patient

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED

ACOEM Guidelines are quite clear and approve surgical treatment for this patient.