

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 28, 2003

RE: MDR Tracking #: M2-03-0853-01-ss
IRO Certificate #: 5242

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon 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 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

The claimant is a 55 year old female complaining of severe low back pain and pain radiating to lower extremities worse on left. Relates pain to fall from chair onto buttocks while working at ___. Significant prior history of prior accidents and four low back surgeries with fusion at L4 and L5 levels with pedicle screw and cage fusion at L4 in 1997. Returned to work but continued to have pain and also had intervening accidents and then fall on ___. When initially seen on 3-12-02 by the chiropractor her right lower extremity was more painful. On 6-2-02 an Orthopaedic Surgeon, also noted more pain complaint on right. When seen by the doctor in October 2002 the complaints were predominantly on the left. MRI on 4-3-02 noted the fusions and a broad-based disc bulge to the left at L3 and facet hypertrophy. The doctor thought it demonstrated Grade I spondylolisthesis and neural foraminal stenosis bilateral. He recommended decompression and fusion at the L3 level. Her neurological findings by multiple examiners have been variable, and positive Waddell signs have been noted.

Requested Service(s)

Fusion at L3 level with pedicle screws and anterior cage with lumbar decompression and epidural block.

Decision

I agree with insurance carrier that these services are not medically necessary.

Rationale/Basis for Decision

There are no specific consistent physical findings that document neural compression at the L3 level. She has negative sitting straight leg raise, and positive supine. There is no mention of quadriceps weakness until 7 months post injury and it is on the left not the right which was the principal complaint immediately post injury, and no evidence of absent patellar reflex. Sensory findings are variable and most of them suggest L5 root involvement i.e. left lateral leg is most consistent finding. The original post injury complaints are predominately on the right post accident and then switched to the left side. Her complaints prior to her surgeries were on the right. There is no description of a lumbar spine series with oblique views that would demonstrate spondylolisthesis if it existed. This condition is better diagnosed on quality x-rays than on MRI. She has no flexion-extension views to document lumbar instability. There is a vast disparity between the doctor's interpretation of the MRI and that of the radiologist. There is presently insufficient documentation to warrant invasive procedures.

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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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)).

This decision by the IRO is deemed to be a TWCC decision and order.

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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 28 th day of April 2003.
