

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 15, 2003

RE: MDR Tracking # M2-03-1544-01
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 and has an ADL Level 2. 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 65 year old female with history of injury ___ moving a hose while at ___. Complaints of neck and right foot, she was seen on 4/25/92 with these complaints. No mention of lower back problems until 8/92 and there was a subsequent fall at ___ after slipping on oil. She underwent cervical discectomy and fusion in 1997. She was seen in October 1993 by ___. Low back findings were c/o of right lower extremity pain and decreased sensation S1 was only positive finding on neurologic examination. The next visit in the records I have was on 1/26/99 and she was complaining of left lower extremity pain at that time. The left sided complaints persisted through 12/21/99. On 3/28/2000 ___ describes severe L5 stenosis. The radiologist interprets changes at L4-5 not at L5-S1. They were on right side and there was no nerve root compression, there was a narrow spinal canal with some foraminal narrowing on the right and disc desiccation and bulging at L4. A subsequent MRI in 2003 demonstrated the same findings. ___ notes indicate left sided pain until 9/4/01 when findings were on the right. Findings were variable from right to left from there on. An electromyogram in June 2003 indicated acute left radiculopathy and these changes were also noted on an electromyogram 10/25/94. There was also a fall on the left side in 10/02 when her left lower extremity gave way and a compression fracture of T11 was sustained.

Requested Service(s)

L4 and L5 decompression and fusion. Kyphoplasty T11

Decision

I agree with insurance carrier that above are not medically necessary.

Rationale/Basis for Decision

There is no mention of low back injury on _____. No complaints until months later probably 8/92 and there is another accident mentioned at _____. There is no documentation of lumbar instability in the clinical record. No lumbar flexion-extension views are in the notes nor are any other indicators of instability. Her neurological findings are inconsistent from visit to visit and vary from side to side. The original back complaints were right-sided, MRI findings were on the right at L5 not S1 and the electromyogram indicated left L5 radiculopathy on 2 occasions years apart. In summary, there are no consistent findings in these records that would document the need for the lower back surgery. I find no clinical documentation to relate her problems to the _____ accident including the fall on _____. The MRI findings as interpreted by the radiologist do not indicate any severe lumbar problems and are not inconsistent with findings in a 65 y/o individual with or without back complaints.

YOUR RIGHT TO REQUEST A HEARING

Either party to 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 a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
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 other party involved in this dispute.