

August 4, 2004  
Amended August 13, 2004

MDR Tracking #: M2-04-1609-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ was a 50-year-old teacher for the \_\_\_ when she slipped and fell in the parking lot and injured her back nearly ten years ago on \_\_\_. She was apparently walking to her car with other teachers when she fell and sustained injury to her lower back, left ankle and right knee. Her left ankle recovered and she had no real significant difficulty with it. Her right knee was judged to be a soft tissue strain and she had some difficulty recovering but she did fairly well until four years later when she had arthritis of the knee. She subsequently underwent an arthroscopic debridement of her knee. Her lower back became painful after the injury and continued to be painful. Her low back pain would radiate down her left leg. She was worked up and found to have degenerative arthritis in the lumbar spine, but did not have anything to require surgery. Her symptoms continued and the designated \_\_\_, gave her an 11% whole person impairment rating.

She continued to have symptoms of low back pain and subsequently underwent extensive back surgery on September 2, 1998. \_\_\_ in \_\_\_ performed this. He did a laminectomy and decompression procedure on L3/4, L4/5 and L5/S1 in her back. In other words, he did a three-level decompression and fusion procedure on her. She continued to have difficulties and the record indicates that this surgery did not really give her any significant relief of symptoms. She continued to require medication and continued to be unable to return to work.

\_\_\_ subsequently had another back surgery, which was done on March 6, 2002 by \_\_\_. This time she had a laminectomy with decompression and fusion at L2/3; therefore, this leaves her with a four-level spine fusion in the lumbar area. She continues to treat with \_\_\_, her treating doctor, an orthopedic surgeon who has continued to see her over the years. Her symptoms have continued

and she still has chronic low back pain. She has not been able to return to work He did a recent MRI study on her that demonstrated multiple level degenerative changes, but did not demonstrate any evidence of significant neural compression that could be surgically corrected. She is now 60 years old and \_\_\_ is recommending re-exploration of her fusion with decompression of nerves and re-fusion as indicated.

#### REQUESTED SERVICE

Decompression of the lumbar spine and rearthrodesis of the arthrodesis is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

This patient has multiple-joint degenerative joint disease in her entire spine. She has a fusion of each and every joint in her lumbar spine except the L1/2 joint. Extensive surgical treatment and fusion have failed to give her any relief of her symptoms. She has had many physicians evaluate her and there have been no real significant neurological deficits reported. The current MRI failed to document any evidence of instability or neural compression that should be surgically corrected. She is not a candidate for more surgery on her back.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

#### **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.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 6<sup>th</sup> day of August, 2004.**