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NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 22, 2004

Requester/ Respondent Address:

TWCC
Attention: Gail Anderson
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

Dr. M, MD
Fax: 713-526-1390
Phone: 713-526-8523

Travelers Indemnity Co
Attn: _____
Fax: 512-347-7870
Phone: 512-328-7055

RE: Injured Worker:

MDR Tracking #: M2-05-0396-01
IRO Certificate #: 5242

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

Forté 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 reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The 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.

Submitted by Requester:

- Office records of Dr. M, MD

- Records from Spring Branch Medical Center including notes from prior surgeries.
- Computerized Tomography report 7-1-2004 lumbar spine
- Computerized Tomography report 2-2-04 lumbar spine
- Computerized Tomography report 2-12-03 lumbar spine
- Discogram 3-6-99
- EMG report 4-2-01
- Epidural steroid injections 3-6-00 and 9-21-99 Dr. N
- Lumbar MRI 8-10-99 showing no disc herniation.
- EMG report 8-31-99

Submitted by Respondent:

- Multiple utilization reviews
- Required Medical Examination 5-27-04 Dr. L, MD

Clinical History

This is a thirty-eight year old female with lifting injury at work on _____. She did not improve on conservative treatment and underwent laminectomy at L4 and L5 levels on 9-5-01. The first surgery failed, and subsequent two level fusion was done on 5-2-02 at L4 and L5 levels, this surgery failed and on 5-3-03 the fixation devices were removed and fusion at L4 and L5 was redone. That surgery has also failed, and repeat fixation removal and fusion is recommended.

Requested Service(s)

Hardware blocks bilateral L4-S1; exproation; posterior hardware removal L4-S1 with possible reinstrumentation posterior, posterior lumbar fusion, posterior lumbar interbody fusion; autograft with 2 day los.

Decision

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

Rationale/Basis for Decision

The prior surgeries have failed because they did not address the patients underlying lumbar problem. There is no evidence in the medical literature to support the use of spinal arthrodesis when there is no evidence of spinal instability. There is no indication of instability in any of the medical records. Clinical Guideline Number 14, page 90, published by US Department of Health Human Services states: "There appears to be no good evidence from controlled studies that spinal fusion is effective for any type of acute low back problems in the absence of spinal fracture or instability."

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) 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.

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 22nd day of December 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: