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NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 14, 2005

Requester/ Respondent Address:

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

Dr. Stephen Esses
Fax: 713-986-5741
Phone: 713-986-5740

Lumbermens Mutual Casualty Co
Attn: Robert Josey
Fax: 512-346-2539
Phone: 512-346-5533

RE: Injured Worker:

MDR Tracking #: M2-05-1766-01
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 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:

- Records from Stephen I. Esses, MD

Submitted by Respondent:

- No clinical records submitted

Clinical History

This is a 56-year-old female who sustained a lumbar spine injury on ___ when she fell backwards while applying labels to boxes while at work. She complains of persistent low back pain radiating to both lower extremities. She has a normal neurological examination and no evidence of lumbar instability. She has positive discogram at 3 levels L3-S1 with negative discogram at L2.

Requested Service(s)

Lumbar decompression, instrumentation and bone graft L3-S1 with a 2 day inpatient stay.

Decision

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

Rationale/Basis for Decision

There are no clinical indicators for lumbar fusion in this patient. Carragee et al, at Stanford University has presented a series of papers to the North American Spine Society documenting the unreliability of discography as a diagnostic tool in the worker's compensation patient. There is no evidence of lumbar spinal instability or spinal stenosis in this patient. She has a normal neurologic examination. She has lumbar spondylosis and there are no reliable studies in the medical literature to support lumbar fusion as a treatment for her condition.

There are no lumbar flexion-extension x-rays demonstrating translatory instability. Gibson, Waddell, and Grant in the Cochrane Review Library, Issue 4, 2004, Chichester, UK: find no scientific evidence about the effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. AHCPR Clinical Guideline #14 pp. 88-90 finds no evidence that spinal fusion is efficacious in the absence of 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 14th day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder