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NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 15, 2005

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

Helson Paceco-Serrant, MD
Fax: 915-751-7554
Phone: 915-534-5288

Employers Ins of Wausau
Attn: Melissa Rodriguez
Fax: 512-231-0210
Phone: 512-231-0202

RE: Injured Worker:
MDR Tracking #: M2-05-1987-01
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 Claimant/Requester:

- Imaging report of the lumbar spine dated 12/10/04 from El Paso Orthopedic Surgery Group MRI Department

- Operative report dated 1/31/05 by Carlos O. Vieska, M.D.
- Operative report dated 12/13/04 by Carlos O. Vieska, M.D.
- RME dated 5/3/05 by Renee Arredondo, M.D.
- Medical documents of the El Paso Orthopedic Surgery Group

Submitted by Respondent:

- Imaging report of the lumbar spine dated 12/10/04 from El Paso Orthopedic Surgery Group MRI Department
- Peer review analysis dated 5/31/05 by Vernon Mark, M.D.
- Medical documents of the El Paso Orthopedic Surgery Group
- Utilization review report dated 5/2/05
- Utilization review report appeal dated 6/2/05

Clinical History

The claimant has a history of chronic back and leg pain allegedly related to a compensable injury that occurred on or about _____. The claimant is status post discectomy with decompression of foramen at L4/5 and L5/S1 in September 2003.

Requested Service(s)

Arthrodesis, anterior interbody technique lumbar spine

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally spinal fusion is indicated in the presence of acute or chronic instability, pseudoarthrosis, or other significant pathology of disc resulting in progressive neurologic deficit. There is no documentation of acute instability or progressive instability over time to indicate the medical necessity of fusion. There is no documentation of a pseudoarthrosis or other significant disc pathology with resultant progressive neurologic deficit to indicate the medical necessity of interbody fusion. The claimant exhibits a normal neurologic exam with mild nerve root tension signs. Symptoms are static and the clinical condition has been documented as "post laminectomy syndrome", a chronic pain condition often associated with arachnoiditis. Documentation indicates the claimant has responded to epidural Cortisone injection. There is no documentation of exhaustion of all usual and customary conservative measures of treatment including but not limited to bracing, physical therapy emphasizing dynamic spinal stabilization/Pilates, corticosteroid medication, and nonsteroidal anti-inflammatory medications. There is no documentation to support the diagnosis of radiculopathy. Imaging studies indicate a patent canal. There are no clear nerve root filling defects documented. There are no EMG/NCV studies documenting isolated nerve root deficit. I strongly recommend continued conservative management of the claimant's chronic pain syndrome. There is no documentation to support the medical necessity of interbody fusion in this clinical setting.

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 15th day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder