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## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** September 1, 2005

**Requester/ Respondent Address:** DWC  
Attention: Gloria Covarrubias  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-1609

John Milani, MD  
Attn: Jude  
Fax: 214-630-2228  
Phone: 214-630-7499

Trenton Weeks, DC  
Attn: Ruonoa  
Fax: 972-613-4335  
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Trinity Universal Ins Co  
Attn: Doug Mahan  
Fax: 888-557-8599  
Phone: 214-360-8552

**RE: Injured Worker:**  
**MDR Tracking #:** M2-05-2218-01  
**IRO Certificate #:** IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) at the Texas Department of Insurance has assigned the above referenced case to Forté for independent review in accordance with DWC 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:**

- Records from John C. Milani, MD
- Myelogram-CT report 5-6-05
- Operative report from Richard Guyer, MD
- Records from Pedro Nosnik, MD
- Records from Stephen Fowler, MD, PhD
- Records from Trenton D. Weeks, DC
- Records from Martin D. Jones, MD
- Records from Dallas Spine Rehabilitation
- EMG report from Pedro Nosnik, MD

**Submitted by Respondent:**

- RME Donald M. Mauldin, MD
- Review from Robert F. Halladay, MD
- RME from Dorothy Leong, MD

**Clinical History**

This is a 39 year old female complaining of severe low back pain radiating to her right lower extremity since a work injury on \_\_\_\_\_. She has had previous IDET at L4 and synthetic disc replacement at L4 with no improvement. She has also failed epidural steroids, anti-inflammatories, analgesics, and physical therapy. An MRI study on 2-22-05 indicated no nerve compression and facet arthropathy. A myelogram and CT with contrast on 5-6-05 showed no disc herniation or spinal canal stenosis; there was mild to moderate foraminal stenosis at L4 and L5 and facet arthropathy. Her electrodiagnostic studies were normal.

**Requested Service(s)**

Inpatient stay, interbody and lateral fusion at L5-S1 with cage implant, pedicle screws and rods, posterior lumbar decompression of L4-5 and L5-S1, bone matrix, bone marrow aspirant and local bone far graft.

**Decision**

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

**Rationale/Basis for Decision**

There is no support in the medical literature for the above services. There are no physical or diagnostic findings regarding the above patient that would warrant the proposed procedure. I have enclosed the surgical indicators for lumbar fusion from Milliman and Roberts 9th edition, along with the annotated bibliography. I would recommend careful attention to the 1st five references.

# Annotated Bibliography

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See Lumbar Surgery Annotated Bibliography for a discussion of key literature.

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## References

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  2. Fritzell P, et al. 2001 Volvo Award Winner in Clinical Studies: Lumbar fusion versus nonsurgical treatment for chronic low back pain: a multicenter randomized controlled trial from the Swedish Lumbar Spine Study Group. *Spine* 2001;26(23):2521-32; discussion 32-4. [ Context Link 1 ] View abstract...
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  5. Kwon BK, et al. Indications, techniques, and outcomes of posterior surgery for chronic low back pain. *Orthopedic Clinics of North America* 2003;34(2):297-308. [ Context Link 1, 2, 3 ] View abstract...
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  23. Manchikanti L, et al. Evidence-based practice guidelines for interventional techniques in the management of chronic spinal pain. *Pain Physician* 2003;1(1):3-81. [ Context Link 1 ]

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## Footnotes

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[A] Wide geographic variations in use of fusion surgery suggest a poor level of consensus on its indications despite its rapidly expanding use.(1)(2)(3)(4) Instrumentation use (eg, internal fixation, surgical implants) generally does not improve clinical results and has higher complication rates, operative time, blood loss, reoperation rates, and costs.(3)(5)(6)(7)(8)(9) [ A in Context Link 1 ]

[B] Although fusion is used for lumbar spinal stenosis with spondylolisthesis, review of randomized controlled trials of laminectomy with or without fusion suggests no difference in outcomes.(15) Multiple laminotomies for decompression may avoid adding a fusion to the surgery.(16) [ B in Context Link 1 ]

[C] Painful spondylolisthesis in children and in patients with high grades of spondylolisthesis are the most accepted indications for spinal fusion.(3) [ C in Context Link 1 ]

[D] Surgical treatment of scoliosis may consist of decompression and fusion with segmental instrumentation.(18)(20) [ D in Context Link 1 ]

[E] See Clinical Indications for Procedure in this guideline. [ E in Context Link 1 ]

[F] NG suction may be necessary after anterior fusion. [ F in Context Link 1, 2 ]

[G] Use oral or parenteral pain medication as needed. [ G in Context Link 1 ]

## 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 1<sup>st</sup> day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder