



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

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. H, MD
Fax: 806-723-7786
Phone: 806-725-4855

Texas Mutual Insurance Co
Attn: _____
Fax: 512-404-3980
Phone: 512-322-8518

RE: Injured Worker:

MDR Tracking #: M2-05-0385-01

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:

- Radiograph report post total knee replacement dated 2/5/04
- Clinical documents of Dr. H from 1/28/04 thru 9/21/04

Submitted by Respondent:

- Case summary dated 11/23/04 prepared by ____

Clinical History

The claimant has chronic right knee pain allegedly related to a compensable injury that occurred on or about _____. The claimant is 10 months status post right total knee arthroplasty. The last clinical documentation by Dr. H indicates a functional range of motion with full extension and flexion to 115°. Dr. H indicates that the “knee itself looks good”. There is no clinical documentation of findings consistent with reflex sympathetic dystrophy.

Requested Service(s)

Outpatient stay at Highland Medical Center for lumbar epidural steroid injection with catheter.

Decision

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

Rationale/Basis for Decision

Generally, reflex sympathetic dystrophy is a diagnosis of exclusion and has a typical clinical presentation that includes sympathetic nerve dysfunction. The diagnosis is generally made by performing sympathetic nerve blocks and, if successful, a decision is made to proceed with formal sympathectomies as treatment. There is no documentation to support a diagnosis of reflex sympathetic dystrophy upon review of the documentation provided. The claimant has shown slow progressive improvement clinically following a total knee replacement and should continue to do so in the future. Furthermore, there is no documentation of exhaustion of usual and customary conservative measures of treatment including, but not limited to, oral non-steroidal anti-inflammatory medication, oral corticosteroid medication, physical therapy, and bracing. Continued conventional conservative management is strongly indicated 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 22nd day of December 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: