

THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3135.M2



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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 8, 2004

Requester/ Respondent Address:

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

Dallas Fire Insurance Co c/o Downs Stanford, PC
Attn: ____
Fax: 214-748-4530
Phone: 214-748-7900

RE: Injured Worker:

MDR Tracking #: M2-05-0388-01
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:

- Notes from Life Chiropractic
- Notes from Millenium Chiropractic

- Epidural steroid injection dated 3/24/04
- MRI report dated 2/18/04
- Electrodiagnostic studies dated 4/12/04

Submitted by Respondent:

- Document from ___ PC
- Record review by Dr. C, Ph.D
- Record review Dr. N, D.C.
- Designated Doctor evaluation Dr. K, M.D.

Clinical History

This 40 year old female had a low back injury at work on ____. She complains of right sided lumbar pain radiating to right lower extremity. Her neurologic examination is normal. Epidural steroids, analgesics, chiropractic, and physical therapy are not effective in pain relief. Electrodiagnostic studies 4/12/04 were normal. MRI report 2/18/04 indicates lumbar arthritis with mild canal stenosis at L3-4 and an annular tear with shallow central disc protrusion at L4-L5. The remaining levels were unremarkable. She was placed at MMI on 5/18/04 by Dr. K.

Requested Service(s)

L2-3 and L3-4 discogram with CT to follow.

Decision

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

Rationale/Basis for Decision

There are no clinical indicators for discography. Carragee, et al at Stanford University have shown discography is not of any diagnostic value in patients with compensable low back complaints and with psychological problems such as depression. These articles were presented to the North American Spine Society and were published in the journal Spine in 1999 and 2000. AHCPR Guideline # 14 page 79 does not recommend discography as a diagnostic tool in low back pain patients. ___ has no surgical indicators and discography is not indicated in patients with her clinical presentation.

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 8th day of December 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: