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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. E, DC
Fax: 936-856-9571
Phone: 936-856-8470

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

RE: Injured Worker:

MDR Tracking #: _____ M2-05-0473-01

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 Requester:

- Clinical documents of KSF Orthopedic Center
- EMG/NCV study performed by Dr. L of Bryan Neurology Services, PA
- Physical therapy documents of _____, PT

- Clinical documents of Advanced Ortho Rehab, PA
- Clinical documents of Twelve Oaks Hospital Department of Radiology
- Peer review dated 8/12/04
- Appeal dated 9/14/04

Submitted by Respondent:

- Peer review dated 8/12/04
- Appeal dated 9/14/04
- Clinical documents of KSF Orthopedic Center
- Clinical documents of Houston Spine Surgery
- Discography report dated 7/8/04 from Twelve Oaks Hospital
- Radiology documents of Twelve Oaks Hospital
- EMG/NCV report
- MRI of the cervical spine report of St. Joseph Regional Healthcare Center dated 6/18/03

Clinical History

The claimant has a history of chronic neck pain and left shoulder pain allegedly related to a compensable injury that occurred on or about _____. The mechanism of injury allegedly related to a backward pulling motion. EMG/NCV reports are remarkable for a left C7 radiculopathy. There is no documentation of motion segment level instability at any cervical motion segment level.

Requested Service(s)

Anterior cervical fusion, anterior instrumentation, autograft to C2-C7, posterior cervical fusion, posterior instrumentation and autograft to C3-C7.

Decision

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

Rationale/Basis for Decision

Generally fusion is indicated in the presence of well documented motion segment level instability and/or pseudoarthrosis. There is no documentation of motion segment level instability at any cervical motion segment level. The claimant exhibits diffuse degenerative arthritis at all cervical levels. The only pain generator site identified is a left C7 radiculopathy. There is no clearly documented clinical rationale explaining why a simple decompression at C7 would be any less effective than a multilevel fusion of the cervical spine in this clinical setting. Discography, while controversial, is not a primary diagnostic tool but a confirmatory study in the presence of an established diagnosis of motion segment level instability when spinal fusion is anticipated. There is no documentation of flexion/extension views documenting acute motion segment level instability nor is there documentation of a progressive angular deformity over time to indicate the medical necessity of cervical fusion.

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: