7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
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NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 17, 2005

Requester/ Respondent Address:

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

Dr. B, DO
Attn: ___
Fax: 903-731-4202
Phone: 903-731-9599

Amcomp Assurance Corp
Attn: ___
Fax: 512-732-8259
Phone: 512-651-0809

RE: Injured Worker:
MDR Tracking #: M2-05-0526-01
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 Care Clinics Dr. B, D.O.
- Notes from Dr. T, D.O.
- MRI report dated 5/21/04
- Ultrasound spine study report dated 7/6/04

- Nerve conduction study report, somatosensory evoked potentials and dermatosensory evoked potentials done by Dr. M, M.D. dated 5/21/04

Submitted by Respondent:

- Reviews from Dr. V and Dr. R, orthopaedic surgeons
- NCV report done by Dr. M
- Lumbar MRI report dated 5/21/04
- Notes from Dr. G, M.D. dated 11/3/04

Clinical History

This 40 year old male has a history of lumbar injury when he fell out of his truck on his back on ___. Complaints of low back pain radiating to his lower extremities, worse on the right, have persisted since the date of injury. He denies previous problems. He has not responded to epidural steroids and treatment with a traction table. He was seen by Dr. G who is a neurosurgeon and he found an absent Achilles reflex and decreased sensation around the right knee region. He also noted positive straight leg raise bilaterally. The electrodiagnostic studies demonstrated multiple nerve root involvement in the lumbar spine on the dermatomal evoked responses, but normal nerve conduction in the major peripheral nerves to the lower extremities. The MRI notes a disc herniation at L5 and a small protrusion at L4.

Requested Service(s)

Transforaminal lumbar interbody fusion L5-S1 with 2-3 los.

Decision

I agree with insurance carrier that the above procedure is not medically necessary.

Rationale/Basis for Decision

The etiology of this man's pain is undetermined. The electrodiagnostic studies suggest a multi level neuropathy rather than a specific nerve root involvement. The absent Achilles reflex on physical exam by Dr. G indicates the fourth lumbar root is involved as well as sensory loss around the knee which would be L4 or L5 not S1. There are no flexion-extension lumbar x-rays in the record. These would be needed to document lumbar instability. Without instability, there is no indication for fusion. Until the source of this gentleman's complaints is documented, there is no indication for surgical intervention.

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 17th day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: