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**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** January 26, 2005

**Requester/ Respondent Address:**

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

Richard R Francis, MD  
Attn: Victor Anaya  
Fax: 713-383-7500  
Phone: 713-383-7100

Zurich American Insurance Co c/o FOL  
Attn: Katie Foster  
Fax: 512-867-1733  
Phone: 512-435-2262

**RE: Injured Worker:**

**MDR Tracking #:** \_\_\_\_\_ M2-05-0613-01  
**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:**

- EMG nerve conduction study report dated 4/29/04
- MRI cervical spine report dated 2/6/04
- Operative report, cervical epidural steroid injection dated 4/29/04
- Clinical documents of Spine Associates of Houston, LLC, dated 3/9/04, 6/15/04, 6/22/04, 11/6/04.

**Submitted by Respondent:**

- Non-certification notice by Zurich Services Corporation Managed Care dated 11/15/04
- Reconsideration of non-certified notice of Zurich Services Corporation Managed Care dated 12/8/04

**Clinical History**

The claimant has a history of chronic neck pain allegedly related to a compensable injury that occurred on or about \_\_\_\_\_. The mechanism of injury is reported to be a slip and fall accident while working at a car wash. The claimant has a history of neck pain, back pain and shoulder pain. The claimant's neck pain has improved with physical therapy.

**Requested Service(s)**

Anterior cervical decompression and fusion at C5-C7 left side nerve root decompression.

**Decision**

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

**Rationale/Basis for Decision**

Generally, indications for decompression include specific identification of pain generator sites regarding radiculopathy. The current documentation does not support a two-level decompression. An EMG nerve conduction study report indicates findings consistent with chronic left C6 radiculopathy. There is no clearly identified two-level pain generator site. Generally fusion is indicated in the presence of clear documentation of motion segment level instability, generally associated with trauma, degenerative conditions, or non-union where pain generator site has been clearly identified at that motion segment level. Upon review of all documents submitted there is no documentation of flexion/extension views indicating instability. There is no documentation of progressive angular deformity over time indicating instability. An MRI report indicates diffuse degenerative changes at C3-4, C4-5, C5-6 and C6-7. It is not clear from the documentation submitted why a two-level fusion is indicated in the presence of diffuse degenerative changes throughout the cervical spine. The claimant has exhibited improvement in clinical condition with physical therapy, and I strongly recommend continued conservative treatment 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 26<sup>th</sup> day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder