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NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 14, 2005

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

Ryan D. Potter, MD
Attn: May De Los Santos
Fax: 361-882-5414
Phone: 361-882-4452

Ace American Insurance Co
Attn: Javier Gonzalez
Fax: 512-394-1412
Phone: 512-394-1442

RE: Injured Worker:
MDR Tracking #: M2-05-0866-01
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:

- MRI report dated 5/26/04 from Spectrum Imaging
- Clinical documents of Dr. Ryan N. Potter, M.D. from Comprehensive Pain Management

- Utilization review dated 12/15/04 from Intracorp
- Utilization review appeal dated 1/3/05 from Intracorp

Submitted by Respondent:

- Clinical documents of Dr. Ryan N. Potter, M.D. from Comprehensive Pain Management
- IME dated 8/10/04 by Dr. Bernard Perron, M.D.
- MRI report dated 5/26/04 from Spectrum Imaging
- Medical documents of Concentra Medical Centers
- FCE dated 10/14/04 from Corpus Christi Pain Relief Center, LLC

Clinical History

The claimant has a history of chronic back and left thigh pain allegedly related to a compensable work injury that occurred on or about _____. Mechanism of injury of the alleged compensable event is compatible with a repetitive use injury. FCE has raised significant questions regarding reliability/accuracy of the claimant's subjective reports of pain/limitation.

Requested Service(s)

Discogram at four levels of the lumbar spine under fluoroscopic guidance with sedation and follow up CT scan

Decision

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

Rationale/Basis for Decision

Generally work up of radiculopathy includes EMG/NCV study to objectively verify clinical suspicion of nerve root involvement. Review of medical records by Dr. Ryan N. Potter, M.D. indicate the claimant has symptoms of "continuous pain down to the toes" which causes tingling, numbness and dysesthetic sensations in those areas. There is no documentation of EMG/NCV study objectively quantitating the presence of radiculopathy. Discography is not the confirmatory diagnostic test for evaluation of radiculopathy.

Generally discography is a confirmatory study in the presence of significant motion segment level instability when fusion is anticipated. There is no documentation of a significant instability at a motion segment level of the lumbar spine to indicate the medical necessity of fusion. There is no documentation of flexion/extension views.

I strongly recommend continued conservative management in this clinical setting. The claimant may benefit from a well structured home exercise program emphasizing dynamic spinal stabilization, bracing, and activity modification.

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 14th day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder