



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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 18, 2005

Requester/ Respondent Address:

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

Nelson Brice, MD
Fax: 325-573-0925
Phone: 325-573-8594

Texas Mutual Insurance Co
Attn: Ron Nesbitt
Fax: 512-404-7094
Phone: 512-404-7273

RE: Injured Worker:

MDR Tracking #: M2-05-0989-01

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 a orthopedic surgery 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:

- None received

Submitted by Respondent:

- Denial of service letter by physician advisor.
- Notes form Dr. Pal
- Office notes from Nelson Brice, MD
- Details describing proposed scooter
- Lumbar MRI report 8-2-01
- Notes from Robert Carr, MD
- X-ray report left hip 3-25-04.

Clinical History

This is a 71 year old male who sustained a crush injury on _____. He had an acetabular fracture on the left. He developed avascular necrosis of the femoral head and underwent left total hip replacement in March 1994. He did well for about 10 years and returned to work. He developed osteolysis and loosening of his total hip in 2004; and on 6-18-04, he underwent a revision total hip. In August 2004 he dislocated his revision hip and had closed reduction. He is now complaining of severe hip and low back pain and is requesting a power scooter to accomplish his activities of daily living.

Requested Service(s)

Purchase of Power Scooter and Vehicle Lift

Decision

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

Rationale/Basis for Decision

A power scooter is not the appropriate DME device for _____. He needs an orthopaedic wheelchair with extendable legs and removable arm rests. This should be a self-propelled wheelchair as there is no mention of upper extremity problems. If his vehicle is not big enough to accommodate the wheelchair, wheelchair carriers are available. He also needs to know how to transfer from bed to chair in a safe manner.

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 18th day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder