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NOTICE OF INDEPENDENT REVIEW DECISION

Date: March 21, 2005

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

Robert J. Henderson, MD
Attn: Amada S.
Fax: 214-688-0359
Phone: 214-688-0078

Zurich American Insurance Co c/o FOL
Attn: Kelly Pinson
Fax: 512-867-1733
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RE: Injured Worker:
MDR Tracking #: M2-05-0991-01
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:

- Clinic note by Dr. Henderson dated 12/23/04
- MRI of the lumbar spine dated 12/17/04
- EMG/NCV study from Dr. Vandewater, PM&R of 12/16/04
- EMG/NCV of the lower extremity on 10/15/04

Submitted by Respondent:

- RME evaluation, Dr. Kirkwood on 12/21/04
- Peer review by Dr. Moses, D.C. of 10/11/04
- Carrier's position note on 2/22/05

Clinical History

On 8/5/04 Dr. Olivia performed a nerve root decompression at L4/5 on the right side. On 10/11/04 peer review notes showed the claimant had therapy from 3/30/04 through 4/30/04. On 10/15/04 NCV of the lower extremity showed evidence of lower extremity radiculopathy using the New Med Nerve Conduction Monitoring System. On 12/16/04 EMG/NCV studies showed no evidence of lumbosacral radiculopathy. Dr. Vandewater, PM&R, felt the claimant to have discogenic pain. On 12/17/04 MRI of the lumbar spine showed degenerative disc disease at L4/5 with central and left sided disc protrusion extending into the lateral recess and neural foramen with impingement on the thecal sac. There was central canal stenosis on the left side at L4/5 with lateral recess and foraminal stenosis on the left side at L4/5. There was no evidence of spondylolysis or spondylolisthesis. On 12/21/04 Dr. Kirkwood felt the claimant to not be at MMI. On 12/23/04 Dr. Henderson noted the claimant incurred injury in ___ when he was moving 55 gallon drums and incurred injury to his low back. The claimant reported symptoms of low back pain with radiation to his right leg with numbness and tingling. The claimant has had chiropractic treatment, VAX-D treatments for a period of 9 months. Dr. Henderson felt the claimant to have spondylosis at L3/4, L4/5 and L5/S1 with spinal stenosis at L4/5 with a herniated nucleus pulposus. The claimant has lumbar radicular pain. Dr. Henderson wanted to rule out discogenic pain and requested lumbar discography at the lower 3 lumbar levels.

Requested Service(s)

Lumbar discogram with CT scan

Decision

I disagree with the carrier and find that the requested service is medically necessary.

Rationale/Basis for Decision

Given that the claimant has multiple levels of pathology of the lumbar spine this request is necessary. The claimant has EMG/NCV showing no evidence of radiculopathy. The claimant has continued back pain. The use of the lumbar discogram and CT scan is indicated to determine if there are sites of discogenic pain at the multilevels of the lumbar spine. This will help guide further treatment including non-operative treatments and pre-operative planning if the claimant fails nonoperative treatments.

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.

<p>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 <u>21st</u> day of <u>March</u> 2005.</p> <p>Signature of IRO Employee:</p> <p>Printed Name of IRO Employee: Denise Schroeder</p>
