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NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 18, 2005

Requester/ Respondent Address:

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

John T. Port, MD
Fax: 972-288-3340
Phone: 972-288-3331

Dallas County c/o Harris & Harris
Attn: Barbara Sachse
Fax: 512-346-2539
Phone: 512-346-5533 x 118

RE: Injured Worker:

MDR Tracking #: M2-05-1162-01
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

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Submitted by Respondent:

- Appeal letter from Trenton D. Weeks, DC
- Office note from J. Teig Port, MD
- MRI report right foot 6-14-04
- Physical therapy notes from Town East Rehabilitation Center

Clinical History

___ claims injury to right foot and ankle after falling from a step stool at work on ___. She has complained of chronic foot and ankle pain since. The chiropractic record indicates symptoms involving the area of the first and second metatarsal bases and the medial cuneiform which is the mid foot. The bone scan apparently demonstrated increased uptake in this area. Dr. Port notes posterior tibial tendinitis which would be unrelated to the bone scan findings. The MRI on 6-14-04 was of the foot not the ankle, and showed no abnormalities in the areas noted above by either chiropractor Weeks or Dr. Port.

Requested Service(s)

Osteotomy right Os Calcis to correct excess valgus deformity of hind foot.

Decision

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

Rationale/Basis for Decision

There are no clinical findings in the records I have reviewed that are consistent with posterior tibial tendinitis. There is no physical examination in the records I reviewed other than Dr. Port noting she had excessive calcaneal valgus. There is no report on foot or ankle x-rays which should have been done including weight bearing lateral of the right foot and an os calcis view weight bearing with measurement of the valgus angle of the calcaneus. There should be an MRI of the right ankle that would demonstrate an abnormal signal in the posterior tibial tendon and show edema in the tendon sheath. The findings on the bone scan would be more consistent with a Lisfranc injury (injury to the ligaments at the cuneiform metatarsal bases), however, there is no clinical correlation with this and the MRI does not demonstrate abnormality in that area. In summary, there is no established diagnosis in this case that would indicate the need for any surgical procedure.

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.

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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 April 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder