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## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** May 6, 2005

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

Jacob Rosenstein, MD  
Attn: Cheryl  
Fax: 817-465-2775  
Phone: 817-467-5551

ARCFI  
Attn: Raina Robinson  
Fax: 479-273-8792  
Phone: 972-389-6741

**RE: Injured Worker:**  
**MDR Tracking #:** M2-05-1271-01  
**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:**

- Medical documents of DNI (Diagnostic Neuro Imaging) including a report of CT of the lumbar spine with contrast dated 2/1/05

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- Medical documents of Jacob Rosenstein, M.D.
- RME report of Mark E. Huff, Jr., M.D. dated 5/18/04

**Submitted by Respondent:**

- Medical documents of Jacob Rosenstein, M.D.
- Medical documents of North Texas Neurology Associates including EMG/NCV study report dated 7/3/03
- Medical documents of Bowie Memorial Hospital including MRI report of lumbar spine dated 6/6/03
- Peer review document of UniMed Direct dated 2/16/05
- Appeal document of UniMed Direct dated 3/1/05

**Clinical History**

The claimant has a history of chronic back pain alleged related to a compensable injury that occurred on or about \_\_\_\_\_. The claimant is status post L4/5 and L5/S1 micro lumbar discectomy on 11/1/04. The claimant continues to have complaints of back and leg pain. The claimant was employed as a stocker for the WalMart stores.

**Requested Service(s)**

Lumbar myelogram with post CT scan

**Decision**

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

**Rationale/Basis for Decision**

Generally a myelogram is a pre-operative study performed when surgical intervention is deemed to be medically necessary. There is no documentation of a clinically significant neurocompressive lesion to indicate the medical necessity of surgical intervention. The claimant exhibits a negative straight leg raise test bilaterally and also exhibits normal strength in all lower extremity muscle groups. A CT scan with contrast reveals no significant evidence of recurrent disc herniation at either previous motion segment level operative sites. There is no documentation of exhaustion of all usual and customary conservative measures of treatment including but not limited to oral nonsteroidal anti-inflammatory medications, corticosteroid medications, bracing, and physical therapy emphasizing dynamic spinal stabilization, as well as a weight loss program.

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## **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 6<sup>th</sup> day of May 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder