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NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 3, 2005

Requester/ Respondent Address:

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

Dr. Tony Ghiselli
Fax: 915-534-5220
Phone: 915-533-7465

Lowe's
Attn: Robert Josey
Fax: 512-346-2539
Phone: 512-346-5533

RE: Injured Worker:

MDR Tracking #: M2-05-1593-01
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 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:

- Letter of medical necessity dated 5/11/05 by Dr. Antonio Ghiselli

Submitted by Respondent:

- Peer review dated 1/24/05
- Appeal dated 3/8/05

Clinical History

The claimant has a history of chronic low back pain allegedly related to the compensable injury that occurred on or about _____. The claimant has returned to full duty work. The claimant exhibits a normal neurologic exam.

Requested Service(s)

Epidural steroid injection

Decision

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

Rationale/Basis for Decision

Generally, epidural steroid injection is indicated for radicular symptoms that have not responded to usual conservative measures of treatment. The claimant exhibits a normal neurologic exam and there is no documentation of radicular symptoms. Symptoms are described as recurrent chronic back pain with strenuous activities. An MRI scan reportedly shows arthrosis of the lower lumbar motion segment levels. There is no documentation of exhaustion of usual and customary non-invasive conservative measures of treatment including, but not limited to, oral non-steroidal anti-inflammatory medication, corticosteroid medications, bracing, and a well structured exercise program emphasizing dynamic spinal stabilization. The documentation does not support the medical necessity of the requested invasive procedure. I strongly recommend continued conservative management in this clinical setting.

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 3rd day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder