



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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 14, 2005

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

Renato Bosita, MD
Fax: 972-494-6075
Phone: 972-205-1890

Texas Mutual Insurance Co
Attn: Ron Nesbitt
Fax: 512-404-3980
Phone: 512-322-8518

RE: Injured Worker:
MDR Tracking #: M2-05-1719-01
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:

- MRI report of lumbar spine from Prime Diagnostic Imaging dated 11/10/04
- Clinical documents from Dr. Andrew R. Block, PhD

- Clinical documents from Texas Back Institute in Garland, TX
- Peer review by Texas Mutual Insurance Company dated 4/15/05
- Appeal peer review by Texas Mutual Insurance Company dated 8/2/04

Submitted by Respondent:

- Clinical documents from Quantum Richardson
- Clinical documents from Texas Back Institute in Mesquite, TX
- Clinical documents from Dr. Andrew R. Block, PhD
- MRI report from Prime Diagnostic Imaging of lumbar spine dated 11/10/04
- Peer review by Texas Mutual Insurance Company dated 4/15/05

Clinical History

The claimant has a history of chronic back pain allegedly related to the compensable injury on _____. The claimant sustained a calcaneus fracture on this date. There is documentation of exacerbation of pre-existing degenerative spine condition with use of crutches while rehabilitating from calcaneus fracture. The claimant is 5'7" tall and weighs 328 pounds.

Requested Service(s)

Please address prospective medical necessity of the proposed Charite disc replacement at level L5-S1, regarding the above mentioned injured worker.

Decision

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

Rationale/Basis for Decision

Generally, surgical fusion and/or disc replacement are indicated following exhaustion of all conservative measures of treatment and following documentation of a clearly identified pain generator site at a single motion segment level with supporting radiographic evidence of instability, pseudoarthrosis, or other significant pathology. There is no documentation of exhaustion of all usual and customary conservative measures of treatment including, but not limited to, weight loss, physical therapy emphasizing dynamic spinal stabilization and non-steroidal anti-inflammatory medications and corticosteroid medications. There is no documentation of instability or other significant disc pathology at any motion segment level. MRI report indicates diffuse degenerative disc disease at several lumbar segment levels. There are no flexion/extension views to indicate significant instability at any motion segment level. A discogram report indicates multiple levels of pain response including concordant pain at L3-4 and L5-S1. Finally, evaluation by a licensed psychologist indicates that the claimant is not a surgical candidate and would be a good candidate for a multidisciplinary pain program. Furthermore, the psychologist's notes states other risk factors including smoking. 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 14th day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder