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NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 27, 2005

Requester/ Respondent Address:

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

Khosrow Zolfogharry, MD
Fax: 915-532-0118
Phone: 915-532-7579

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

RE: Injured Worker:

MDR Tracking #: M2-05-1809-01
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:

- Records from K. Zolfoghary, MD
- MRI report 6-30-04
- Discogram and CT with contrast 4-4-05
- Letter from Dr. Jonathan Twigg
- Lumbar myelogram 2-11-05 and CT with contrast
- Incomplete EMG report 4-7-05

Submitted by Respondent:

- Records from Dr. Zolfoghary
- Discogram and CT report
- Myelogram and CT report
- Records from Lynn Neill, MD
- Evaluation by Dr. Sandberg 1-18-05.

Clinical History

This is a 49 year-old-male who injured his back picking Chili's on _____. He experienced immediate low back pain with radiation to his lower extremities. He has no neurologic deficits and his low back pain is his chief complaint. His imaging studies show no significant disc pathology and no spinal stenosis. He has annular tears at L4 and L5 on MRI and discography, but there was no pain response at those levels with discography.

Requested Service(s)

Lumbar laminectomy left L5-S1

Decision

I agree with the insurance carrier that the above services are not medically necessary.

Rationale/Basis for Decision

The indications for lumbar laminectomy are persistent disabling leg pain with neurologic findings that correspond anatomically with the pain distribution. The imaging studies should confirm the history and physical examination findings. This is not the case with Mr. _____. He has no findings on examination or on his numerous imaging studies that indicate any specific nerve root involvement or disc herniation and there is no necessity for any invasive procedures.

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 27th day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder