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NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 19, 2005

Requester/ Respondent Address:

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

Helson Pacheco-Serrant, MD
Attn: Elida
Fax: 915-542-6786
Phone: 915-533-7465

Wausau/Liberty Mutual
Attn: Carolyn Guard
Fax: 574-258-5349
Phone: 574-258-4400 x 2487

RE: Injured Worker:

MDR Tracking #: M2-05-2142-01
IRO Certificate #: IRO 5263

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:

- Clinical documents of El Paso Orthopedic Surgery Group
- CT/discogram of lumbar spine report dated 5/3/05 from El Paso Orthopedic Surgery Group MRI Department

- CT of lumbar spine report dated 2/23/05 from El Paso Orthopedic Surgery Group MRI Department

Submitted by Respondent:

- Peer review from Liberty Mutual Group dated 6/3/05
- Appeal report dated 6/24/05 from Liberty Mutual Group
- Clinical documents of El Paso Orthopedic Surgery Group and Center for Sports Medicine

Clinical History

The claimant has a history of back pain and right leg pain allegedly related to a compensable injury that occurred on or about _____. Clinical studies indicate pre-existing facet arthrosis.

Requested Service(s)

Two level artificial disc replacement

Decision

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

Rationale/Basis for Decision

CT of the lumbar spine report dated 2/23/05 indicates foraminal stenosis at L5/S1 on the right. A CT/discogram of the lumbar spine report dated 5/3/05 documents right sided foraminal “disc protrusion” at L5/S1. There was no focal disc pathology seen at L4/5 or L3/4. Clinical studies indicate symptoms and physical findings consistent with a clinical diagnosis of foraminal stenosis. There is no documentation of instability on plain films with flexion/extension views or documentation of angular deformity over time. There is no documentation of exhaustion of all usual and customary conservative measures of treatment including but not limited to epidural Cortisone injections, bracing and corticosteroid medication. Ultimately, the surgical standard of care for the treatment of foraminal stenosis is decompression. There is no clearly documented clinical rationale explaining why a simple decompression would be any less effective than interbody fusion or disc replacement in this clinical setting should the claimant fail to respond to exhaustion of all usual and customary conservative measures of treatment. The documentation does not support the medical necessity of 2 level artificial disc replacement.

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 19th day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder