

NOTICE OF INDEPENDENT REVIEW DECISION

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August 29, 2005

Requestor

Robert J. Henderson, MD
ATTN: Amada S.
1261 Record Crossing
Dallas, TX 75235

Respondent

State Office of Risk Management
ATTN: Jennifer Dawson
P.O. Box 13777
Austin, TX 78711

RE: Injured Worker: _____
MDR Tracking #: M2-05-2043-01
IRO Certificate #: IRO4326

The TMF Health Quality Institute 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 a TMF physician reviewer who is board certified in Orthopedic Surgery, by the American Board of Orthopaedic Surgery Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1969, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 51 year old female injured her back on ___ while trying to prevent a client from falling. She has been treated with medications, therapy, and epidural steroid injections.

Requested Service(s)

Anterior interbody fusion L5-S1, retroperitoneal exposure and discectomy L5-S1, anterior interbody fixation L5-S1, posterior decompression L5-S1, transverse process fusion L5-S1, posterior internal fixation, bone graft, allograft, bone graft, autograft in situ, bone graft, autograft iliac crest, bone marrow aspirate, length of stay 2 – 3 days

Decision

It is determined that the Anterior interbody fusion L5-S1, retroperitoneal exposure and discectomy L5-S1, anterior interbody fixation L5-S1, posterior decompression L5-S1, transverse process fusion L5-S1, posterior internal fixation, bone graft, allograft, bone graft, autograft in situ, bone graft, autograft iliac crest, bone marrow aspirate, length of stay 2 – 3 days is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation does not substantiate the medical necessity for the performance of circumferential fusion. This procedure is usually limited to revision or failed fusion surgery. The procedure has significant risk and cannot be justified as a primary surgical approach to what appears to be a single level of degenerative disc disease.

This decision by the IRO is deemed to be a TWCC decision and order.

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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

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The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

cc: _____, Injured Worker
Program Administrator, Medical Review Division, TWCC

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 carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 29th day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Used by TMF in Decision

Patient Name: _____

TWCC ID #: M2-05-2043-01

Medical record documentation provided:

- Treatment Records
- Diagnostic Tests
- Designated Doctors Evaluation
- Maximum Medical Improvement
- Independent Medical Examination
- Procedure Notes
- Hospital Record
- Claims