

NOTICE OF INDEPENDENT REVIEW DECISION

Barton Oaks Plaza Two, Suite 200  
901 Mopac Expressway South • Austin, TX 78746-5799  
Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

August 29, 2005

Requestor

Coastal Spine Medical Center  
ATTN: Adriana Vasquez  
2727 Morgan Ave., Ste 300  
Corpus Christi, TX 78405

Respondent

Liberty Mutual Fire Insurance Co.  
ATTN: Carolyn Guard  
Fax#: (574) 258-5349

RE: Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-05-2163-01  
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 male patient injured his back on \_\_\_\_ in a work related event. He has been treated with medications and therapy.

Requested Service(s)

Refusion of the lumbosacral spine and lumbar laminectomy and decompression at the L4-L5 level and L5-S1 level.

Decision

The refusion of the lumbosacral spine at the L5-S1 level is medically indicated, however, the lumbar laminectomy and decompression at the L4-L5 and L5-S1 is not medically indicated to treat this patient's condition.

Rationale/Basis for Decision

The medical record does not provide sufficient documentation to indicate the medical necessity for the surgical procedure as it is requested. There is no documentation to indicate neural compression. However, an attempt to achieve fusion at L5-S1 was performed on 08/13/2004. This attempt appears to have failed. Refusion at L5-S1 does appear indicated by the presence of psuedarthrosis and symptoms of back pain and findings of bilateral lower extremities.

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.

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 #:** M2-05-2163-01

**Medical record documentation provided:**

- **Progress Notes**
- **Diagnostic Tests**
- **Maximum Medical Improvement**
- **Requests**
- **Claims**