

NOTICE OF INDEPENDENT REVIEW DECISION

Bridgepoint I, Suite 300
5918 West Courtyard Drive • Austin, TX 78730-5036
Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

April 13, 2006

Requestor

Frederick D. Todd, MD
ATTN: Irene
800 W. Arbrook Blvd., Ste 250
Arlington, TX 76015

Respondent

Texas Mutual Insurance Co.
ATTN: Richard Ball
Fax#: (512) 224-3980

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-0925-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC 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 Neurological Surgery, by the American Board of Neurological Surgery, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1986, 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 the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on 10/21/2004 when he was removing tile from the floor. When getting up, he hit his back on a mechanic type ledge and immediately began to experience pain in his lower back with radiation into his left lower extremity. The patient has been treated with physical therapy.

Requested Service(s)

Lumbar discogram with post-discogram CT scan at L3-4, L4-5, and L5-S1

Decision

It is determined that the lumbar discogram with post-discogram CT scan at L3-4, L4-5, and L5-S1 is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has sustained a lumbar spine injury that has not appropriately responded after 1 ½ years of conservative treatment. An MRI and a myelogram/CT scan have identified abnormalities at L3-4, L4-5, and L5-S1. EMG testing is consistent with L5 radiculopathy. Clinical notes indicate that the patient's symptoms are "75% back pain and 25% leg pain" and thus a fusion procedure is under consideration. Under these clinical circumstances, lumbar discogram is an acceptable diagnostic tool that is widely utilized and medically appropriate and necessary.

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

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 Department of Insurance, Division of Workers' Compensation, 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

cc: Program Administrator, Medical Review Division, DWC

In accordance with Division 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 13th day of April 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Attachment

Information Submitted to TMF for Review

Patient Name: Thomas W. Ridl

Tracking #: M2-06-0925-01

Information Submitted by Requestor:

- Neurological Surgery Consultation History and Physical
- Report of Lumbar Myelogram and CT
- Neurophysiological History and Physical
- Electrodiagnostic Results
- Neurological Follow up Evaluations
- Case Management initial visit/ History and Physical
- Case Management Follow up Visits
- Neurological surgery follow up evaluations

Information Submitted by Respondent:

- Letter from Texas Mutual to TMF
- Patient assessment from Concentra Medical Centers
- Report of MRI of the lumbar spine
- Neurophysiological History and Physical
- Electrodiagnostic Results
- MMI and Impairment Rating
- Neurological Follow up Evaluations
- Pain Management-Interventional Pain Management follow up visits
- Decision letter