

NOTICE OF INDEPENDENT REVIEW DECISION

February 24, 2006

Requestor

Kenneth G. Berliner, MD
ATTN: Brenda Gonzalez
15769 North Freeway
Houston, TX 77090

Respondent

Hartford Casualty Insurance Co.
ATTN: Barbara Sachse
Fax#: (512) 343-6836

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-0433-01
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 Orthopedic Surgery, by the American Board of Orthopaedic Surgery, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1964, 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 ___ when she experienced low back pain following repetitive bending and lifting while packing and moving boxes. Treatment has included previous laminectomy, a discogram and a myelogram of the spine.

Requested Service(s)

Anterior discectomy at L4-5 ALIF with cages, exploration fusion, revised PLF at L5-S1, PLF at L4-5 with 3 day length of stay.

Decision

It is determined that the anterior discectomy at L4-5 ALIF with cages, exploration fusion, revised PLF at L5-S1, PLF at L4-5 with 3 day length of stay is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This multilevel extensive spine surgery is not medically indicated. The patient is said to be neurologically intact and there are no motion films to document instability. The patient has not responded to facet injections, IDET, or revision fusion at L5-S1. It appears that the patient has multiple levels of degenerative disc disease and due to the poor success rates of the proposed surgery, it is determined that the extensive spine surgery is not medically appropriate.

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

GBS:dm
Attachment

cc: Injured Worker
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 24th day of February 2006.

Signature of IRO Employee:
Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name:

Tracking #: M2-06-0433-01

Information Submitted by Requestor:

- Review determination from The Hartford
- Orthopaedic Knowledge Update Chapter 35
- Lumbar x-ray reports
- CT report of lumbar spine
- MRI report of lumbar spine
- Exam report from Dr. Ramzy
- Nerve conduction study
- Operative report
- Report of lumbar myelogram
- Functional capacity evaluation
- Orthopedic Reports
- PEER Review
- Clinic Visit Notes
- Table of Disputed Services
- Letter of Medical Necessity for Lumbar Discogram
- Physician Advisor Review
- Report of Medical Evaluation
- History and Physical
- Impairment Rating Report
- Pre-authorization letter for IDET
- Letter of Medical Necessity for CT myelogram
- Pre-authorization letter for discectomy with interbody fusion
- New Patient Evaluation
- PT evaluation
- Examination by Dr. Likover

Information Submitted by Respondent:

- Review determination from The Hartford
- Orthopaedic Knowledge Update Chapter 35
- Orthopedic Reports
- CT report of lumbar spine
- MRI report of lumbar spine
- Electromyography Report
- Operative Reports
- Myelogram Report
- Report of Lumbar Discogram