

NOTICE OF INDEPENDENT REVIEW DECISION

January 23, 2006

Requestor

James A. Guess, MD
ATTN: Isable
4780 N. Josey Lane
Carrollton, TX 75010

Respondent

Liberty Mutual Insurance Co.
ATTN: Carolyn Guard
100 Lincolnway West
Mishawaka, IN 46544

RE: Claim #:
Injured Worker: _____
MDR Tracking #: M2-06-0439-01
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 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 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 he injured his back while trying to move a refrigerator. He began to experience low back pain radiating to his foot. A discogram performed on 07/18/2005 revealed evidence of concordant pain at L5/S1 without evidence of pain reproduction at L3/4 and L4/5.

Requested Service(s)

Charite artificial disc replacement at L5-S1

Decision

It is determined that the Charite artificial disc replacement at L5-S1 is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient's evaluation has revealed at least two elements of classical circumstances that are included as contraindications for Charite disc arthroplasty. Specifically, an MRI scan performed 12/21/2004 suggested degenerative disc disease at 2 levels (L4-L5 and L5-S1). Multi-level disc herniation is included as a contraindication. In addition, a 6mm subligamentous disc herniation with radial tear was demonstrated. Herniated nucleus pulposus with compressive radiculopathy is also suggested as a contraindication to this procedure. Current literature¹ related to this procedure is limited. Only short term results have been reported. Although the procedure offers theoretical benefit, clinical benefit over a long-term has not been reported. It would be best to consider this procedure experimental at this time.

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

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

<p>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 23rd day of January 2006. Signature of IRO Employee: Printed Name of IRO Employee:</p>

¹ Guyer RD;McAfee, PC; Hochschuler, SH ;et al (TX BACK INST, Plano TX) SPINE J4:2525-2593 2004