

NOTICE OF INDEPENDENT REVIEW DECISION

June 28, 2006

Bridgepoint I, Suite 300  
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Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

Requestor

Arvo Neidre, MD  
ATTN: Leticia Trevino  
9150 Huebner Road, Ste 350  
San Antonio, TX 78701

Respondent

EMCASCO Insurance Co. c/o Flahive,  
Ogden & Latson  
ATTN: Katie Foster  
504 Lavaca, Ste 1000  
Austin, TX 78701

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M2-06-1525-01  
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 Medicine, 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 was driving his truck and was apparently hit from behind. This resulted in immediate onset of severe low back and right leg pain. The patient has been treated with surgery as well as epidural steroid injections.

Requested Service(s)

Outpatient right L1-2 facet injection

Decision

It is determined that the outpatient right L1-2 facet injection is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the lumbar facet may be a contributing source to the patient's present symptoms. With a solid fusion from L2 to S1 present, additional stress is placed on the facet joints proximal to the fusion mass. Such additional stress could contribute to the development of symptoms based on facet arthrosis. The diagnosis of this syndrome is presumptive and there are no studies which objectively establish the diagnosis. The only way to establish the diagnosis appears to be treating the syndrome with facet joint injections of local anesthetic and corticosteroid preparation. If relief of symptoms is achieved, the diagnosis is established. Therefore, there is sufficient documentation and mechanical pathophysiologic understanding to justify the facet joint injections.

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.

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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,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

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 28th day of June 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

**Patient Name:** \_\_\_\_

**Tracking #:** M2-06-1525-01

**Information Submitted by Requestor:**

None

**Information Submitted by Respondent:**

- Office Notes from Dr. Neidre
- Letters from Dr. Neidre
- Office Notes from Dr. Joyner
- Physical Therapy Progress Notes
- Operative Reports
- Report of the MRI of the lumbar spine
- Report of the CT scan of the lumbar spine
- Report of the lumbar myelogram and post myelogram CT
- Report of chest x-ray