

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

September 12, 2006

Requestor

Robert J. Henderson, MD  
ATTN: Amada S.  
1261 Record Crossing  
Dallas, TX 75235

Respondent

Texas Municipal League  
c/o Flahive, Ogden & Latson  
ATTN: Katie Foster  
504 Lavaca, Ste 1000  
Austin, TX

RE: Claim #: \_\_\_\_\_  
Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-06-1872-01  
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 hit his head during a high speed chase as a police officer. This caused injury to his neck, right shoulder and low back. The patient subsequently underwent a 3-level cervical fusion as well as multiple right shoulder procedures and a lumbar fusion.

Requested Service(s)

Posterior decompression L4-L5, intraoperative decision for transverse process fusion at L4-L5, posterior internal fixation L4-5, bone graft, allograft bone graft, autograft ileac crest, bone marrow aspirate, and cybertech TLSO.

Decision

It is determined that the Posterior decompression L4-L5, intraoperative decision for transverse process fusion at L4-L5, posterior internal fixation L4-5, bone graft, allograft bone graft, autograft ileac crest, bone marrow aspirate, and cybertech TLSO is not medically indicated to treat this patient's condition.

Rationale/Basis for Decision

The indication for posterior decompression requires some evidence to suggest that symptoms and physical findings are the result of compression neuropathy. Although the myelogram CT of 07/22/05 suggested central canal compromise L4-L5 as a result of hypertrophy ligamentum flavum, there are no physical findings to suggest that this hypertrophy and canal compromise has resulted in compressive neuropathy. There is no evidence of nerve root sleeve abnormalities. Solid fusions from L4 to S1 are demonstrated and there is no documentation to suggest that instability of the lumbar spine exists. The medical record documentation does not substantiate the medical indication for the procedure. The surgical procedure does not meet the indication criteria utilizing common standards of practice published in ODG, Fromeyer Spine, recent Instruction Course notes, and multiple peer review literature articles.

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.

M2-06-1872-01  
Page 3

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 12th day of September 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

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

**Tracking #:** M2-06-1872-01

**Information Submitted by Requestor:**

- Request for Preauthorization for Surgery
- Chart notes from Dr. Henderson
- Operative note for a caudal epidural steroid block
- Report of lumbar discogram and post discogram CT scan
- Report of lumbosacral myelogram and post myelogram CT scan

**Information Submitted by Respondent:**

- Letters from the attorneys
- Table of Disputed Services
- Preauthorization review