TMF
Health Quality Institute

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NOTICE OF INDEPENDENT REVIEW DECISION

January 19, 2007

Requestor

Texas Back Institute
ATTN: Cory
6020 W. Parker Rd., Ste 200
Plano, TX 75093

Respondent

Texas Municipal League
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
504 Lavaca, Ste 1000
Austin, TX 78701

RE: Claim #:
Injured Worker: ___
MDR Tracking #: M2-07-0593-01
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, who is a police officer, sustained a work related injury on __ when he was working at a shooting range picking up spent shells. This resulted in aching, burning, and intermittent stabbing back pain radiating into the right buttock. The patient has been treated with epidural steroid injections as well as participation in a pain management program.

Requested Service(s)

Arthroplasty L4-5 and fusion L5-S1

Decision

It is determined that the arthroplasty L4-5 and fusion L5-S1 are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation does not substantiate the medical necessity for the surgical procedure requested at this time. Current spine literature is concentrating on “patient selection” for these spine procedures. Disc arthroplasty remains an investigational procedure. Recent studies indicated that 2 years post surgery, outcomes appear comparable (no better) than spine fusion. Theoretical advantages have not been shown to be realized. Complication rates appear to be greater in disc arthroplasty procedures. Outcomes at 2 years for patients with “mechanical low back pain” treated non-operative and operatively (spine fusion) also appear comparable. It would appear that fusion for mechanical low back pain would be considered only after 2 years of failure to achieve relief. Therefore, it is determined that the arthroplasty L4-5 and fusion L5-S1 are not medically 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

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 19th day of January 2007.

Signature of IRO Employee:

Printed Name of IRO Employee:

Attachment

Information Submitted to TMF for Review

Patient Name: ___

Tracking #: M2-07-0593-01

Information Submitted by Requestor:

- **Discogram Report**
- **Report of MRI of the Lumbar Spine**
- **Operative Note**
- **Report of Arthrogram**
- **PEER to PEER request for arthroplasty**
- **Followup notes from Dr. Guyer**
- **PEER to PEER review by Dr. Jasmnski**
- **PEER to PEER Visit by Dr. Marchetti**
- **Followup notes from Dr. Marchetti**
- **New Patient Visit notes by Dr. Guyer**
- **Followup notes from Dr. Jasinski**
- **Report of Consultation and Physical Examination by Dr. Jasinski**
- **Report of Consultation by Dr. Marchetti**

Information Submitted by Respondent:

- **Letter to TMF from Attorneys**
- **Table of Disputed Services**
- **Determination letters**
- **Initial Request for Services**
- **Preauthorization request**
- **PEER to PEER request for arthroplasty**
- **Followup notes from Dr. Guyer**
- **Followup notes from Dr. Marchetti**
- **Discogram Report**
- **Report of MRI of the lumbar spine**
- **Operative Notes**
- **Radiographic Interpretation Notes**
- **Report of Consultation by Dr. Marchetti**
- **PEER to PEER review by Dr. Jasmnski**
- **PEER to PEER Visit by Dr. Marchetti**
- **New Patient Visit notes by Dr. Guyer**
- **Rebuttal by Dr. Marchetti**
- **Report of Consultation and Physical Examination by Dr. Jasinski**