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NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 18, 2005

Requester/ Respondent Address:

TWCC
Attention: Gail Anderson
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

Robert LeGrand, MD
Fax: 325-657-0875
Phone: 325-655-4164

TAC WC Self Insurance Fund c/o Parker &
Associates
Attn: William Weldon
Fax: 512-320-9967
Phone: 512-320-9950

RE: Injured Worker:

MDR Tracking #: M2-05-0762-01-SS
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 an Orthopedic reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Records from Dr. LeGrand
- Lumbar myelogram and CT reports 4-23-04
- Discogram report 3-14-03

Submitted by Respondent:

- Notes from Dr. LeGrand
- Records from Shannon Medical Center
- Records from Dr. Mark Sanders

Clinical History

This 49 year old female was injured lifting a patient from a shower chair to a geri chair on _____. She complained of persistent back pain. She underwent a 2 level fusion at L4 and L5 by Dr. LeGrand on 4/25/03. Post-operatively she continues to be symptomatic and continues with low back pain and pain radiating to her thighs. Flexion-extension lumbar x-rays showed no instability at L3-L4 on 12/30/04. Lumbar myelogram and CT with contrast were reported as: thecal sac deformity on the myelogram and severe facet hypertrophy and ligamentum flavum thickening on 4/23/04. Dr. Sanders report on 4/24/04 states that she related she was worse since surgery. She had no complaints of extremity pain and no complaints of extremity numbness or weakness. She had limited lumbar motion and no neurologic deficits.

Requested Service(s)

Inpatient stay x 1 day for lumbar laminectomy with fusion and instrumentation L3/4.

Decision

I agree with the insurance carrier that the above procedure is not medically necessary.

Rationale/Basis for Decision

This is a patient who was made no better by the first extensive surgery. She has no lumbar instability at the level in question. She is neurologically intact. There are no consistent reproducible physical findings indicating nerve root compromise. Her principle problem is lumbar facet arthritis which is consistent with her complaints and physical findings. Federal Clinical Practice Guideline #14 finds no indication in patients with her clinical picture page 88-89 for spinal fusion. The Cochrane Review issue 4, 2004 by Gibson JNA, Waddell G., and Grant IC, reviews the world literature regarding surgery for degenerative lumbar spondylosis including associated back pain, instability, spinal stenosis and degenerative spondylolisthesis. The reviewer's conclusions indicate there is no scientific evidence about the effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

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 a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
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 other party involved in this dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 18th day of February 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder