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NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 6, 2005

Requester/ Respondent Address:

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

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

Texas Mutual Insurance Co
Attn: Ron Nesbitt
Fax: 512-404-3980
Phone: 512-322-8518

RE: Injured Worker:

MDR Tracking #: M2-05-1163-01
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 a orthopedic surgery 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:

- MRI report from Midland Imaging Center 10/26/04

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- CT lumbar spine report from Shannon West Texas Memorial Hospital dated 12/28/04
- Radiology report of myelogram of lumbar spine from Shannon West Texas Memorial Hospital dated 12/28/04
- Radiology report of CT of lumbar spine after discography dated 01/14/05
- Operative report of discography from Shannon West Texas Memorial Hospital dated 01/14/05
- Medical documents of Robert H. LeGrand, Jr., M.D., FACS

Submitted by Respondent:

- Case summary dated 04/20/05
- MRI report from Midland Imaging Center dated 10/26/04
- CT lumbar spine report from Shannon West Texas Memorial Hospital dated 12/28/04
- Operative report of discography of lumbar spine from Shannon West Texas Memorial Hospital dated 01/14/05
- Required Medical Exam by Dr. Curtis J. Spier, M.D. dated 01/25/05
- Medical documents of Robert H. LeGrand, Jr., M.D., FACS
- Peer review by Texas Mutual Insurance Company dated 01/21/05
- Appeal review by Texas Mutual Insurance Company dated 02/03/05

Clinical History

The claimant has a history of chronic “mechanical” low back pain and leg pain allegedly related to a compensable injury that occurred on or about _____. The claimant received chiropractic treatment prior to clinical evaluation by Dr. LeGrand. The claimant has received physical therapy in the form of hot packs and traction and continues to seek chiropractic care. The alleged injury reportedly involved attempting to close a sliding door from left to right on a lathe with onset of back pain.

Requested Service(s)

One day inpatient stay for performance of lumbar laminectomy with fusion and instrumentation and bone stimulator, TLSO back brace.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally surgical decompression of the lumbar spine is indicated when there is a clearly documented neurocompressive lesion that has failed aggressive conservative management. Generally fusion of the lumbar spine is indicated in the presence of instability documented by flexion/extension views or progressive angular deformity, pseudoarthrosis, or other surgical lesion resulting in instability and pain. Upon review of all documentation provided, there is no evidence indicating an isolated neurocompressive lesion that would necessitate decompression. Review of documents does not indicate the presence of instability that would necessitate fusion. A radiology report of myelogram of the lumbar spine dated 12/28/04 documents no intradural or extradural defects and no nerve root amputation. The myelogram clearly documents no evidence of a neurocompressive lesion that would necessitate decompression. There is evidence of diffuse degenerative disc disease of the lumbar spine documented on CT and MRI reports. There is no documentation of flexion/extension views indicating instability of any motion segment level. There is no documentation of angular deformity over time. There is no documentation of any other significant surgical lesion that would necessitate fusion. The rationale for fusion is predicated in part on a discography procedure. Review of the discography reports indicate no control level documented. A discography at L3-4 and L4-5 reproduced pain. The L5-S1 level was not entered. There is no documentation of a control having been performed. There is no documentation of exhaustion of conservative measures of treatment including but not limited to oral non-steroidal anti-inflammatory medications, corticosteroid medications, physical therapy emphasizing dynamic spinal stabilization/pilates or bracing. I strongly recommend clinical reassessment and directing treatment toward aggressive conservative management of the claimant's condition.

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:

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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 6th day of May 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder