

**MEDICAL REVIEW OF TEXAS
[IRO #5259]**

**3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012**

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1442-01
Name of Patient:	
Name of URA/Payer:	Continental Casualty c/o Specialty Risk
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Robert H. LeGrand, MD

May 31, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in neurosurgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Robert H. LeGrand, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

This is a 37 year-old gentleman who injured himself on _____. At that point he was working for _____ and was climbing out of a truck under icy conditions and fell. Since that point he has apparently been having significant back pain with some radiation down his right leg. There was not a complete record of his conservative management but what has been written by the chiropractors, pain management physicians and now surgeons, is that he has received extensive non-surgical management including chiropractic management and multiple different types of therapy. However he has not had any epidural injections. He has had an MRI scan times two which have found him to have degeneration of the L4/L5 disc spaces. Because of his lack of progression a surgical procedure has been recommended.

REQUESTED SERVICE(S)

L4 and L5 instrumented fusion and the purchase of a TLSO brace.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

A chief component is that this patient has not worked in five years, having stopped in 2000 as well as having a multitude of pain descriptors and positions. However, as the treating physician has stated, "he has tried multi-modality management with the possible exception of lumbar injections, be they epidural or facets". Prior to a two level fusion, standard of care would warrant that this patient certainly warrants a trial of either epidural or facet joint injections or a combination of the two. Should that fail, a lumbar discogram would be the next course of action. It is inappropriate to proceed on with a two level fusion based solely on MRI findings.

In summary, this patient needs a trial of interventional pain management. Should that fail the low back pain will have to be further investigated with a provocative discogram prior to consideration for interventional surgery to actually prove that this is discogenic in nature. Further, that study will help to limit the origin of his low back pain.

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 (20 Tex. Admin. Code 142.5©).

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 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the 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 carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 1st day of June 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell