

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-07-0530-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Richard LeGrand, MD

February 14, 2007

An independent review of the above-referenced case has been completed by a 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 the Division of Workers' Compensation 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.

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Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: \_\_\_\_\_  
Richard LeGrand, MD  
Division of Workers' Compensation

RE: \_\_\_\_

DOCUMENTS REVIEWED

1. Notice of IRO Assignment.
2. Texas Mutual Insurance Companies packet of information
3. Dr. Robert LeGrand office visits dated November of 2006 and 1/11/07.
4. Imaging studies including an MRI scan, a CT Myelogram and a CT Discography reports.

CLINICAL HISTORY

This is a 56- year-old woman who injured herself while checking for gas at the pump. She twisted, fell to her knees, and had severe pain in her low back radiating into her right hip and buttock region and then down the right leg. This happened on \_\_\_\_ and then two weeks later she had an MRI scan which found her to have multi level degenerative changes with broad based left lateral disc protrusion at L3. I do have this radiology report. She later had a CT Myelogram which was performed on 7/12/06, just shy four months after her original injury. This showed small disc protrusions at L3, L4 and L5 with facet arthrosis at L4 and L5 and only mild potential for neural foraminal encroachment. Following this she had a lumbar discogram performed a little less than five months after her accident on \_\_\_\_\_. This appears to be a straight forward discogram without any provocative aspects of it. The discography was felt to be positive anatomically and physiologically at L4 and at L5. Based upon this, it has been recommended that she have an L4 and L5 decompressive laminectomy and fusion. To date, her conservative management has included physical therapy, anti-inflammatories and lumbar epidural injections without any substantial benefits.

REQUESTED SERVICE(S)

Lumbar laminectomy with fusion at L4 and at L5.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Unfortunately, the majority of this denial comes from the fact that scant information was supplied. There were only two medical records

RE: \_\_\_\_

from Dr. LeGrand, who is the requesting physician, dated 11/13 and 1/11 as well as the three imaging studies mentioned above. However, based upon what the previous reviewer has stated, this patient's remediable factors have not been addressed. Her level of function prior to injury has not been assessed. Her prior history of low back symptoms has not been addressed. It should be noted that she has had a previous MRI scan of her lumbar spine, so something of her background still exists. There is no electromyographic supportive data. In this situation, to offer a patient a two level fusion with such scant supporting data is not standard of care, particularly in light of the fact that this request was made only eight months after her injury, well before she could have completed a comprehensive pain management and reconditioning program. Rationale and basis for this decision comes from not only the ***Occupational Medicine Guidelines***, but also ***The North American Spine Society's*** recommendation for spine fusions, as well as the recommendations outlined by the ***American Association of Neurologic Surgeons*** in their June 2005 report.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and 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.

## 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.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
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 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 15<sup>th</sup> day of February, 2007.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell