

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-04-1248-01
Name of Patient:	
Name of URA/Payer:	Royal Insurance Company of America
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Karl Swann, MD

June 14, 2004

An independent review of the above-referenced case has been completed by a neurosurgeon medical physician. 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: Karl Swann, MD  
Texas Workers Compensation Commission

RE: \_\_\_\_\_

#### CLINICAL HISTORY

The patient is a 37-year-old male who sustained a work related injury 3/10/03 with subsequent low back pain radiating into the left lower extremity. MRI at that time showed a large disc herniation at L4-5 for which he underwent lumbar microdiscectomy in 2003. He now continues to have back and leg pain with weakness and atrophy in the left lower extremity. MRI date 1/16/04 shows multilevel disc bulges at L2-3, 3-4 with scarring and stenosis at L4-5 and L5-S1. He has been a conservative treatment failure and decompression and fusion has been recommended.

#### REQUESTED SERVICE(S)

Medical necessity of L3-S1 lumbar laminectomy discectomy, postero lateral fusion, posterior lateral interbody fusion w/Steffer pedicle screws, Brantigan cages and Dynagraft.

#### DECISION

Approved. The proposed treatment is a medically acceptable treatment option.

#### RATIONALE/BASIS FOR DECISION

This patient has chronic back pain and radicular symptoms which have been unresponsive to conservative treatment. Decompression is indicated for treatment of his lower extremity symptoms while fusion is indicated for chronic back pain. Intra-operative assessment may be necessary for a decision regarding extension of the fusion to the L3-4 level. A combination of posterolateral and interbody fusion with instrumentation has been shown to increase fusion rates dramatically.

## 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 14<sup>th</sup> day of June, 2004.

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

Printed Name of IRO Employee: Cindy Mitchell