

# 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:	M2-04-1388-01
Name of Patient:	
Name of URA/Payer:	Travelers Insurance
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Douglas Beman, DC

June 15, 2004

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: \_\_\_\_\_  
Douglas Beman, DC  
Texas Workers Compensation Commission

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

#### CLINICAL HISTORY

Mr. \_\_\_\_\_ injured himself in August 2001 when he was attempting to lift up a copier which weighed in excess of 200 pounds at a senior center. When lifting, he felt a sharp pain in his low back. He finished out his work shift. However, the pain the following day became quite severe and at that point he started on a long medical journey. He has been evaluated with EMG's and MRI scans: the EMG showing a mild L5 radiculopathy, the MRI scan showing disc desiccation at L5. At some point during his evaluation, the surgical option was raised and Mr. Phillips rejected that option. When he finally agreed with it, he was told that he was too heavy, weighing in excess of 200 pounds. He was told to lose weight and when he did he returned, weighing 185 pounds. It was then that a surgical procedure for dealing with his low back pain was discouraged. He had a lumbar discogram which is somewhat confusing. The documentation from the physician stated that he had somewhat concordant pain with pain into his left leg, and other documentation which states that the study was negative. In essence it showed, however, that the L5 disc space was not fundamentally disrupted. A newer request for a posterior lumbar interbody fusion has been recently made.

#### REQUESTED SERVICE(S)

L5 posterior lumbar interbody fusion with cage and lateral transverse process fusion at L5-S1.

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

The treatment for low back pain, even those that are mechanically generated, is to begin with all remediable factors. The most difficult one in most people is weight loss and reconditioning. This gentleman has demonstrated his ability to participate in his own care by losing

weight. He does have pathology at L5 and S1 based on both his MRI scan and at least by his physicians' interpretation of the discogram. Therefore, the requested surgery is justified.

## 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 \_\_\_15 \_\_\_ day of June, 2004.

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

Printed Name of IRO Employee: Cindy Mitchell