

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled *Medical Dispute Resolution by Independent Review Organizations*, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Therefore, in accordance with §133.308(q)(9), the Commission **Declines to Order** the respondent to refund the requestor for the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The initial inpatient consultation and low back disk surgery were found to not be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Order is hereby issued this 5th day of March 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 26, 2003 - amended

Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-02-2681-01
IRO Certificate #: 5242

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon 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.

Clinical History

Extensive medical records were available for my review, beginning with an employer's first report of injury or illness, dated 1/13/00, for an injury which occurred on ___ at 5:30 p.m. This report indicates that the claimant sustained an injury while at work, with a back bruise, after he was hit on the back by a traveling fan.

An initial medical report for worker's compensation insurance is available from 8/28/00. A handwritten history indicates that the patient was lighting a furnace/heater. As the furnace ignited, it caused him to move back quickly, striking his low back against a fan and injuring his low back. He presented with complaints of low back pain, traveling into the left leg and mid thigh. He reported the pain was constant and stabbing in nature. He rated the pain as an 8/10. He related that sitting or standing for any extended period of time caused difficulty with pain about the low back. An examination was described which indicates that although he had pain across his low back, he was neurologically intact in his lower extremities. A supine straight leg raise was positive on the left at 15° and on the right at 30°. He was tender at the SI joints bilaterally and had decreased range of motion about his back and SI joints.

Recommended treatment included daily treatments for two weeks followed by three times per week for six weeks. Treatment was to consist of joint mobilization, EMS, ultrasound, myofascial therapy, moist heat and cryotherapy, with therapeutic activities and exercises. This is according to ___, chiropractic physician.

___, an orthopedic surgeon in ___ evaluated the claimant for an IME on 12/29/00. ___ relates a similar history of an injury which occurred on ___, when the claimant backed into a fan. He apparently had some superficial abrasions from this and did not seek any immediate medical treatment. He apparently saw ___ two weeks following the injury. X-rays were taken and he was given some medication and was told that there was nothing wrong.

He reported to ___ that he did have a history of a back injury ten years prior, when he had fallen and had some difficulty with back pain. His pain was more on the upper than the lower back and his symptoms resolved. The claimant reported difficulty with radiation to the gluteal areas and that he had been fired from his job on 5/1/00.

He reported his treatment with ___ and reported he had also been referred to ___. ___ also did review an MRI scan, which demonstrated some central bulging of the L5/S1 disc, without any disc herniations. There was mild, borderline, questionable stenosis at the L3/4 and L4/5 levels. Basically, he felt that the MRI scan was "not very abnormal." ___'s diagnosis was that of a ligamentous sprain of the lumbar spine, with mild degenerative lumbar disc disease. He felt that

these degenerative changes present about the lumbar spine were pre-existent to the injury on _____. He felt that he had recovered from the lumbar sprain/strain but still had some symptoms from his ongoing degenerative back disease. He was felt to not be a surgical candidate and had reached a point of MMI with a 2% whole person impairment based on his loss of lateral bending. He was not awarded any additional impairment for the degenerative disease, as it was felt to be a pre-existing condition. He did not feel that the claimant would require any future medical treatment or investigational studies. He recommended that the claimant continue with a home exercise program. _____ actually filled out a report of medical evaluation on 12/29/00, indicating a 2% whole person impairment for this injury dated _____.

Notes are available from _____. He apparently saw the claimant on 1/13/00 and when the patient presented, he was a 34 year old white male from _____. The claimant reported a similar history of having backed into a fan four days prior. The examination demonstrated some bruising of the lower lumbar area, particularly on the right side. There was normal range of motion and he remained neurologically intact. X-rays were negative except for some old arthritic changes.

His impression was that of a back contusion. He recommended heat, massage, stretching, Norflex and Vioxx. He was to continue working at a full duty status.

The claimant returned for evaluation by _____ on 2/4/00. His back was a lot better and completely resolved. He was having some symptoms of carpal tunnel syndrome and was given a carpal tunnel brace and told to continue taking Vioxx.

The claimant was examined by _____ on 8/29/00. He relates a similar history and indicates that the claimant reported continued low back pain radiating down his left lower extremity. His impression was that of classic lumbar radicular syndrome and felt that there was likely a lumbar injury present there. He recommended Celebrex, Soma, Lorcet 10 and recommended the possibility of an MRI scan should his symptoms not improve.

An additional note is available from 11/11/00 in which _____ felt that the claimant had reached a point of MMI as of 11/10/00, with a 0% whole person impairment.

An x-ray radiology service report is available from _____ from 9/15/01, indicating that only a lateral view of the lumbar spine was completed and it was apparently an intra-operative x-ray posterior to the L5/S1 disc space.

An EKG is available from 9/14/01, also from _____.

The claimant was seen by _____ for a designated doctor determination, seen on 1/11/01, regarding his injury on _____. _____ indicates that the claimant had not yet reached a point of MMI. He made further recommendations for treatment. The claimant related similar history as reported by _____ in his report. _____ indicates that the claimant had a trial of oral anti-inflammatories, but had not had formal spine stabilization, physical therapy, Cortisone injections, discogram or myelograms. His impression was that of apparent L2 and L3 radiculitis with possible spinal stenosis and possible disc disruption of the L5/S1 level. He felt that he may have facet mediated pain and epiduritis. He recommended a trial of epidural steroid injections. If these were not helpful, then myography and possible neurosurgical consultation. He also felt that the patient may also be a candidate for discograms, or even fusion.

The claimant was evaluated by ___ on 3/14/01. The claimant related similar history. ___ impression was that of lumbar spondylosis with mechanical back pain radiating towards the left leg with moderate central bulging disc at the L5/S2 on the left, with lumbar radicular irritation, spinal stenosis at the L3/4 and L4/5 levels, possibly causing some epiduritis and radicular irritation. He recommended anti-inflammatories, epidural steroid injections to the left L4/5 level, a trial of Ultram and physical therapy, aqua therapy with gradual progression to land based exercises.

A handwritten note is also available from 7/14/01, handwritten on ___ progress note paper. The handwritten note is dated 3/14/01. However, the hospital stamp on the bottom of the page dates 9/13/01 and indicates that a CT/ myelogram was completed, which demonstrated a large herniated disc at the L5/S1 level, acentric to the right.

An operative report is available from 3/27/01 when the claimant underwent at the ___, a lumbar epidural steroid injection to the L5/S1 level, done by ___.

A mini-peer review report from ___ is available from 2/19/01, in which a chiropractor performing the review felt that the complaints of hand problems were not at all related to this back contusion.

A report is available from ___, a chiropractor, who evaluated the patient on 3/30/01. He does review the records and does note, as we have reviewed above, that two weeks following the injury, his symptoms were completely resolved. Six months later, he presented to a chiropractor, changing his treating physician and told the chiropractor he had not been treated thoroughly in the past. The chiropractor took him off work with subjective complaints of pain rated at an 8/10 with radicular pain into the legs. ___ impression was that his lumbar contusion had completely resolved as of 2/4/00 and that any further treatment or complaints in this 290 pound gentleman with degenerative problems and light stenosis about his back was not at all related to the ___ injury. He found that there was no recommendation for any extended benefits for chiropractic treatment or passive medical modalities. He felt that the claimant did have degenerative changes present, but they were not compensable.

Further notes are available from ___ from 4/18/01. At that time, the claimant reported that had nearly 100% relief following the epidural steroid injection and was gradually having return of symptoms and at the time of this evaluation on 4/18/01, had only 60% of his relief. He was felt to also be objectively better and ___ recommended repeating the epidural steroid injection and even considering a third if that was helpful.

On 4/19/01 the claimant was taken back to surgery by ___ for a second epidural steroid Cortisone injection done under IV conscious sedation.

___ saw the claimant back again on 6/4/01. He also reported excellent relief from this injection. He reported a pain level of 3, with 80% overall improvement. The claimant at that time was working at this own construction company and ___ felt that he could return to those activities at that present job. He did not think the bulging disc or with the limited type of work he was doing at that time, would require any further treatment for his back. He was given no refills on his medications.

___ saw the claimant back again for a designated doctor impairment rating on 7/16/01 regarding this injury of ___. At that time, he felt that he claimant had reached a point of MMI as of that day, 7/16/01, with a 5% whole person impairment. He reported that the epidural steroid injections had been somewhat helpful. The claimant's pain that day was a 4/10. The claimant definitely was not interested in surgery. He only had two of the epidurals out of three and had not yet had the third. He was not taking any regular medications. He felt that he had internal disruption of the L5/S1 disc, with lumbar facet syndrome and radiculitis. He felt that the claimant would not require surgery for this problem, and, in fact, the claimant had expressed a strong desire to not have surgery. He felt that his current treatment plan was appropriate and that he might benefit from an additional steroid injection and perhaps some lumbar facet injections as well. He felt that he claimant's condition was stable and that the impairment rating was unlikely to change in the near future.

The claimant saw ___ again on 7/23/01. He was having some recurrence of pain in his low back and left leg at that time. His last injection had been 3.5 months prior and he had done extremely well following those injections until just before this visit. His impression was lumbar spondylosis; post traumatic lumbar syndrome with mechanical left back, buttock and leg pain; central bulging of the L4/5 disc, spinal stenosis and radiculitis of the left upper L5.

On 8/14/01, ___ performed a left L5 selective transforaminal epidural steroid injection without dural puncture and under fluoroscopic guidance and under IV conscious sedation.

___ saw the claimant back again on 9/10/01. The claimant reported he had difficulty with severe pain into his left leg following this last epidural injection. He continued to have difficulty with right leg pain, like an electric poker, going from his buttock down into his toes on the right, particularly when he coughed and sneezed. He thought he also had weakness of the leg and difficulty raising his toes. He had noticed some dribbling of his urine, but for the most part, had good normal continence, but did report a strongly positive sneeze/cough effect. At that time, he was 6'4" tall, weighing 298 pound. ___ felt that he likely had an L5/S1 right sided S1 radiculopathy from a disc herniation. He recommended an urgent MRI scan and, depending on the results, a surgical opinion. He recommended restarting Paxil as the patient was tearful and having such severe problems with pain and reactive depression. He was also to take Norco, Senokot and Neurontin.

A report of x-ray examination of a lumbar spine MRI scan, ordered by ___, and performed on 9/12/00 indicates evidence of central bulging at the L5/S1 disc, with no herniations. Borderline spine stenosis was seen at the L3/4 and L4/5 levels.

A history and physical examination is available from 9/14/01, when ___ admitted the claimant. On this admission history and physical, the claimant is described as a "delightful gentleman", 35 years old, whose chief complaint was that of low back pain. Medical clearance was obtained, secondary to his obesity and severe familial history of COPD. His history and physical does not indicate that the patient was in any significant distress at all, and he was apparently cleared for surgery.

A consultation report is available from ___ from 9/14/01. ___ obtained a similar history and did also report that the claimant had some difficulty with two weeks of periodic urinary dribbling,

but no full blown urinary incontinence or fecal incontinence either. He also did not report any erectile dysfunction. The claimant's present medications were Neurontin, Hydrocodone and Paxil. He reviewed the CT scan, which demonstrated a large disc herniation central and to the right of the L5/S1 level. He recommended surgery.

A discharge summary is available from 9/16/01. The discharge diagnosis is that of status post herniated nucleus pulposus at L5/S1 on the right side, with progressive urinary incontinence, extremely large, free fragment at the L5/S1 level, which was apparently displaced to the right. A microdiscectomy was performed. He was discharged with Vicodin, Paxil and Neurontin.

A history and physical is available from ___ on 9/13/01, when he admitted the patient to the hospital with this large extruded disc at the L5/S1 level, confirmed by CT scan. He does report that the open MRI scan obtained previously demonstrated disc bulging, but no disc herniations.

A report from the CT/myelogram is available from 9/13/01 in which ___ notes evidence of a right sided disc herniation at the L5/S1 level with compression of the right S1 nerve root. There is minimal annular disc protrusion at the L1/2, L2/3 and L3/4 levels.

A report of operation is available from 9/15/01, in which ___, assisted by ___, performed an L5/S1 microdiscectomy, removing an extremely large fragment from the L5/S1 disc space acentric to the right. ___ notes in his dictation that the claimant did not have full blown urinary incontinence or fecal incontinence at admission. However, the morning prior to surgery, he had some increased difficulty with dribbling, as he had been having over the previous two weeks. He reports no significant complications at the time of the surgery.

An emergency room note is available from 9/4/01 [sic], when the claimant presented to the emergency room status post discectomy with some worsening of his pain into the posterior aspect of his leg. The impression of the emergency room physician was that of acute exacerbation of low back pain with right radiculopathy status post recent microdiscectomy.

The claimant was seen for a follow up visit with ___ on ___ [sic]. He reports that the claimant had done extremely well following the surgery, with no back pain or leg pain and had returned to work. He had been pain free for approximately four weeks, until his house caught fire, and when he was running from the house, and had acute exacerbation of his back pain at that time. He was given some prescriptions for Vicodin, Soma and given Skelaxin samples, if the Soma made him too sleepy during the day.

A review is available from ___ in which ___ reviews medical records provided to him on 12/10/01. He felt that based on the records, the patient made a full recovery from an injury by 2/4/00 and that the subsequent back pain was not related to the original injury of ___. He felt that the treatment the claimant had received subsequent to that was likely medically necessary, just not related to the accident of ___. He indicated that surveillance video was reviewed, and demonstrated the claimant seemed to be doing symptomatically quite well. He felt that the injury that the claimant was being treating for, for this right sided L5/S1 disc herniation was likely a result of an injury which occurred in August 2001 and was not directly related to the accident of ___.

The claimant was seen again by _____. _____ reported that the claimant had complete resolution of his symptoms, but after one day at work, had recurrence of his pain. In November, his water heater gas leaked and his house caught on fire. He found that the heavy activity required to clean up the fire did exacerbate his back pain. at the time of this evaluation his pain was rated as an 8, with a range of 6 to 10. He recommended L5/Sq selective epidural transforaminal steroid injections, and if this was not helpful, he recommended obtaining another MRI scan to rule out the possibility of another disc fragment.

The claimant was seen by _____ on 9/9/01. _____ reviews much of the same records that I have reviewed here today. He felt that based on the medical records available for review, that medical care for this claimant's back was medically necessary.

He reviewed further records again on 9/22/01, and felt that based on these records, he was 80% improved from his low back pain, following these two epidural injection series. He felt that his treatment was now one of chronicity and recommended for future care occasional anti-inflammatories, home based exercise program with stretching and weigh loss; lumbar discogram at the L2 through L5 levels to rule out the possibility of an annular tear. He felt that if a tear of the lumbar spine disc was discovered, then an IDET procedure would likely render him completely pain free and without residuals.

Some additional work status sheets, and intake sheets are included with these medical records. A release from _____ indicates that the claimant was returned to regular duties on 10/14/01, status post microdiscectomy.

Additional billing information is also included.

Requested Service(s)

I have been requested to evaluate these medical records in a peer review with regard to whether the treatment rendered on 9/14/01 and 9/15/01 was medically necessary.

Decision

I find that the treatment rendered to this claimant while in the hospital on 9/14/01 and 9/15/01 with an L5/S1 microdiscectomy was not medically necessary.

Rationale/Basis for Decision

I do not find that the procedure performed on 9/14/01 and 9/15/01 was performed under emergency conditions. The patient had some dribbling incontinence but no full blown incontinence at the full admission of the operating surgeon. The service requested was an evaluation of a spinal surgery, and this evaluation is within the scope of my practice. In addition, I would agree with _____ evaluation that this type of injury with a contusion to the low back had completely resolved by 2/4/00. The claimant had an MRI scan, which demonstrated evidence of a disc bulging and degenerative changes. A subsequent CT/myelogram performed on 9/13/01 demonstrates evidence of a large, extruded L5/S1 disc herniation, protruding to the right side and impinging upon the S1 nerve root. This claimant is an overweight claimant, weighing in at the range of 300 pounds and had degenerative disc disease and I think it is likely that sometime in

the days or weeks prior to this CT/myelogram, the patient sustained an additional injury, with this L5/S1 disc herniation. I do not find that the need for surgery of this L5/S1 disc herniation is a direct result of the accident of ____, which was a contusion to the low back, when he backed up against a fan.

Hence, my final opinion is that the operation was not performed under emergency circumstances and was not medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 27th day of February 2003.