

December 29, 2003

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TWCC Medical Dispute Resolution  
MS-48  
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MDR Tracking #: M2-04-0484-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurology. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ was evaluated by \_\_\_ on May 27, 1998. He had presented to \_\_\_ for low back pain that resulted from falling off a work stand. This patient complained of back pain that radiated to his left leg. There was a previous injury in \_\_\_ to his back, and he had undergone a lumbar laminectomy with relief of symptoms. He then underwent physical therapy at that time with resolution of his back problem.

The examination on May 27, 1998 stated that the patient was walking with a limp and straight leg raising on the left was positive. The MRI showed a bulging disc at L4/5, but no herniation. It was recommended that he receive epidural steroid injections and return to follow-up. The next visit was on August 4, 1998, stating that the patient had undergone a number of blocks with relief and physical therapy was started. He did not believe that surgery was necessary. On September 1, 1998 he saw \_\_\_ with complaints of pain, despite physical therapy. It was recommended that he see \_\_\_. The patient was also complaining of neck and shoulder pain.

There were medical records from \_\_\_ that he had been receiving during this period of time, and he was discharged on October 15, 1998. He did not improve and was referred to \_\_\_. There was an MRI of the cervical spine done on April 24, 1998 that showed a small disc at C6/7 which was in contact with the ventral surface of the cervical spinal cord and a mild bulge at C5/6.

There was an overall decreased signal intensity of the bone marrow raising the question of metabolic bone disease. The MRI of the lumbar spine was done on April 24, 1998, and it showed abnormal appearance of the bone marrow in that region as well, suggesting metabolic bone disease, and there was only mild evidence of disc changes at L4/5 without herniation. A CT scan of the lumbar spine was done on May 1, 1998, which showed a mild right central paracentral disc bulge at L4/5 without stenosis. There was a bone scan done on May 7, 1998 that was focused on the lumbar spine and it was reported as normal.

\_\_\_ was seen at the \_\_\_ by \_\_\_. He was complaining of pain, which started in his low back, radiating down the posterior lateral aspect of the left leg to the foot. The examination showed some tenderness in the neck. The lower back showed tenderness in the lumbar spine. Straight leg raising showed positive on the left at 40 degrees. No reflexes were detected in the lower extremity. His diagnosis was cervical and lumbar radicular pain and a series of epidural blocks (x3) were recommended. This was to be done in the lumbar and possibly cervical area. The first epidural steroid was done on July 7, 1998 in the lumbar region and a second on July 31, 1998. Epidural steroids were also done in the cervical region on August 18, 1998.

The patient was seen by \_\_\_, a neurosurgeon, on October 19, 1998. The patient complained of left leg pain, low back pain, right shoulder pain, and pain in both arms. His examination showed sciatic notch tenderness on the left and no paraspinal muscle spasm was noted either in the lumbar or cervical area. The motor examination in both upper and lower extremities was normal. The sensory examination showed diminished pain sensation in the left C6 and possibly left L5 area. He recommended a total myelogram and myelogram CT at that time.

He saw \_\_\_ again on December 3, 1998. The myelogram was reported as being insensitive in the lower area and a small thecal sac deformity at C5/6 was noted. In the lumbar area there was evidence of a small disc bulge with focal protrusion to the left of the midline at L4/5. He recommended back surgery, predominately at L4/5 because of the pain in his back and left leg. He would consider doing cervical surgery at another time. The doctor saw the patient on February 8, 1999. He was continuing to have numbness in the left arm, neck pain and an occasional headache. Lumbar laminectomy at L4/5 was recommended, and on March 23, 1999 a left discectomy and foraminotomy at L4/5 were done.

On April 19, 1999 the patient returned to \_\_\_, stating that his back pain had improved but that he was still having numbness in the left leg, though less than pre-operatively. The pain was much better and his incision was healing. \_\_\_ recommended physical therapy. \_\_\_ returned again on May 28, 1999. He had completed physical therapy at that time and wanted to continue further treatment. He was still having left leg and hip pain, but it was not as constant. He was still having left arm and neck pain. \_\_\_ recommended work hardening and a return to see him in follow-up.

In August of 1999 \_\_\_ was still complaining of neck and arm pain, and cervical surgery was recommended to relieve those symptoms.

The patient was seen on January 20, 2000 and it was stated that a cervical post myelogram CT, EMG and nerve conduction studies were indicated. With that information, the patient underwent a cervical discectomy and fusion anteriorly on March 21, 2000, and this procedure was uneventful.

On April 21, 2000 \_\_\_ returned to \_\_\_. He was post-anterior cervical surgery with fusion at C5-C7. His left hand numbness had resolved and he still had weakness on the left side.

Physical therapy and exercises were recommended.

The patient saw \_\_\_ on September 14, 2000. An FCE dated August 30, 2000 found that the patient had completed his work hardening program and goals were met. It was suggested that he was able to return to work and return to his prior job position. His level of work was light/medium with the ability to perform a light physical demand above the waist. He was given a whole body impairment of 27% at that time.

Another MRI of the lumbar spine was done on July 11, 2001, and it showed L4/5 post-surgical changes consistent with a left hemilaminectomy and mild bilateral facet degenerative changes. There was no evidence of disc herniation or recurrent disc herniation. There was no central canal stenosis or neuro foraminal stenosis. There was mild degenerative disc disease. At L4/5 there was minimal disc enhancement which was probably due to degenerative disc disease. They suggested an indium tagged white blood cell scan to rule out the possibility of early discitis.

\_\_\_ was seen on October 25, 2001 by \_\_\_ for continuing back pain which apparently began in October of 2000. The neck pain had started in January of 2001. Epidural steroids were given and they gave him temporary relief. He was complaining at that time of a knife-like pain in the left side of his neck, left side low back pain and left leg pain. He was taking Neruontin, Skelaxin, Zoloft and Cataflam. His examination showed normal tandem gait. Normal heel-to-toe walking, and good normal strength in upper and lower extremities and good sensation in upper and lower extremities. There was mild decreased range of motion of the cervical and lumbar spine. There was mild cervical paraspinal muscle tenderness noted. The MRI findings of July 11, 2001 were reviewed that showed L4/5 post surgical changes. He suggested an indium tag white blood cell scan as was recommended by the radiologist on the MRI report and started him on physical therapy. He also wanted to get another MRI of the cervical spine.

An EMG was done by \_\_\_ on March 8, 2002. The findings in nerve conduction showed the left H-reflex was prolonged, suggesting a possible abnormality at the left L1 region. The needle examination showed positive waves in the left vastus radiolysis with occasional positive waves in the left medial gastroc. This suggested a possible L1 to L4 radiculopathy.

On September 3, 2002 he underwent another lumbar MRI that showed the previous laminectomy at L4/5 and there was mild degenerative marrow signal within the L4/5 vertebra abutting the disc space. There were some degenerative changes at L4/5 with medial facet joint spurring involving the left lateral recess of the left foramen. There may have possibly have been some impingement of the exiting left L4 root. The remaining disc regions were normal. The marrow signal was minimally unremarkable.

The patient was seen on November 11, 2002 by \_\_\_. He was still continuing to have low back pain and left sided leg pain since October of 2000. He also gained sixty pounds. He had epidural steroid injections six months prior with initial improvement, but developed a rash. There were changes on EMG that he reviewed from March of 2002 that showed changes at L4 and S1. It was not stated whether the findings were chronic or new. Because of the patient's inability to respond to the conservative treatment, he recommended a myelogram CT, bone scan and EMG of the lower extremities. The MRI scan that was done on September 3, 2002 showed previous surgery changes and mild compromise of the left lateral recess of L4/5.

Defused degenerative changes were noted throughout the lumbar spine. He recommended further diagnostic testing.

On December 4, 2002 \_\_\_ stated that physical therapy and steroids were not very effective in treating this patient. He also had been on Naprosyn and Soma with no improvement. He was aware of \_\_\_ pain and numbness in the leg. A myelogram as recommended because of the previous EMG changes in the MRI findings.

On March 14, 2003 \_\_\_ saw \_\_\_ with complaints of persistent low back pain. He was still having pain in his back and leg. A myelogram and post-myelogram CT were recommended.

A September 19, 2003 myelogram showed mild defused posterior protrusion of discs at L4/5 with disc narrowing. There was no evidence of lateralization and the nerve roots filled out very nicely. There was a CT of the lumbar spine also done on that same date which showed defused disc bulge at L4/5 and narrowing of this neuro foraminal at L4/5. There was no contact of the nerve roots sleeve.

There was a CT lumbar spine performed on September 19, 2003 that showed a moderate to mild defused disc bulge without involvement of the roots or foraminal at L4/5.

The patient was seen on October 6, 2003 by \_\_\_ who stated that the patient was having trouble getting his EMG and bone scans, but he felt that these needed to be done.

#### REQUESTED SERVICE

An EMG/NCV and bone scan are requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

Based on a review of the medical records, this patient appears to have a lumbar radiculopathy which developed at the time of his injury on \_\_\_. He had a lumbar laminectomy and various other treatments, which were helpful but did not completely eliminate the sensory symptoms and all the pain. There was evidence in follow-up that sometime in October he appeared to have more discomfort in his back and left leg. The original EMG that was done in March of 2002 showed some changes of L4 to S1 and it was not clear that these changes were new or long-standing. It is certainly probable that these findings were probably related to the original injury of \_\_\_. There had not been any previous EMGs at that time to compare. It does not appear evident from the medical records spanning from March of 2002 until the current time of 2003 that the pain in the back and left leg is due to any new radicular involvement. In fact, it is quite clear from the myelogram CT as well as the MRI of the lumbar spine that there was no evidence of any nerve root compression, mostly postoperative changes. The reviewer finds it most likely that this patient has ongoing pain due to muscular pain in the lumbar region or possibly due to previous nerve root irritation that had been present for a number of years.

The reviewer finds that a repeat EMG is not reasonable or necessary. The neurologic examination and the CT myelogram clearly do not show any evidence of a new radiculopathy. A repeat EMG also would not likely show any further abnormalities.

It would either show improvement from previous records or likely the similar findings that were present in 2002. This also would not likely change the treatment program, since there does not appear to be any indication that surgery is necessary.

The reviewer also finds that the requested bone scan is unnecessary as requested. His back pain that is being described is certainly not likely to be discitis. A sedimentation rate would be the test performed if a discitis was suspected. Also, the changes of the bone marrow in the lumbar vertebra were recognized on July 13, 2001 on the lumbar MRI. If there were any serious discitis or bone marrow infiltration by some other disease process, the reviewer would expect a major medical change and lumbar change from July until the present in 2003. As a result, the reviewer finds that the requested bone scan is unnecessary at this time.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to 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 (28 Tex. Admin. Code 142.5(c)).

**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 142.5(c)).

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

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 30<sup>th</sup> day of December 2003.**