

July 28, 2004

MDR Tracking #: M2-04-1574-01
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 board certified and specialized in Orthopedic Surgery. 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

The date of injury was ____. There is somewhat of a discrepancy in the two preauthorization reviews, one was an L4-5 laminectomy discectomy interbody fusion with posterolateral fusion with instrumentation; the other is for a two level procedure.

The mechanism of injury appears not to have been an injury, per se, but a manifestation of back pain while stocking boxes. The patient underwent conservative care with a treating chiropractor and eventually underwent epidural injections, nerve root blocks, and trigger point injections. ___ is the consulting physician and discovered on physical exam essentially normal exam from motor and sensory, muscle tone, deep tendon reflexes, gait and station exam.

An MRI suggested L4-5 concentric disc herniation without nerve root compression. A review of discography that was performed on 8/26/03 suggested concordant pain. ___, on 5/9/03, performed an independent medical evaluation, after ___ had recommended surgery for the injury. ___ reported that the patient had positive EMG with L5-S1 changes on the left, and agreed with the proposed diagnostic discography for determination of surgical procedures. It appears that an original discography was performed, which was reported to be negative, however the patient claimed that he was asleep due to sedation and was not a valid test. The initial preauthorization for discography questioned the necessity for anesthesia during the provocation portion. The basis of the denial was overturned, the test was carried out and now the physician reported that there was an invalid study due to the anesthesia. Eventually a repeat discography was performed revealing 'pain in the lower two levels.'

Multiple physicians have been involved in this patient's care from a treating and reviewing standpoint, including medical and chiropractic physicians and surgeons. To the reviewing physicians, repeated testing and surgical intervention is not felt to be confirmed based on the single level non-compressive central disc protrusion in a pain-focused individual. However, all the examining physicians, including ____, ____, and ____ have concluded that this patient requires surgery for his recovery.

At this point the patient is three years out from injury, reporting intractable, unrelenting pain, despite medication, injection, therapy, manipulations and time. His initial workup did not appear to be of major significance with relatively normal MRI, except for a single level disc protrusion that was non-compressive, a normal discography and some mild nerve changes. The patient has fought for repeat testing, which has show some evolution of disease process, and eventually it appears that all four surgeons have recommended surgery on this patient based on the positive discography (although the Caragee Studies show that using discography as a sole indicator for surgery can have misleading outcomes). In retrospect this may not be as good a predictive value on the success for surgery for painful disc. A fourth surgeon, ____, has recommended surgery at a single level based on diagnostic testing and physical findings. Apparently the patient reported increased pain to the discography, which is a bad prognosticator in regard to Dr. Caragee's Studies. In the spring of 2004 the patient has been reported to go to the emergency room multiple times for pain medicine or pain injections due to increased pain.

REQUESTED SERVICE

A proposed two level laminectomy, discectomy with fusion, L4 to S1 are requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This case does not represent an injury per se, but a manifestation of back pain while performing normal duties. It appears that this patient was appropriately treated with medication and therapeutic maneuvers initially without improvement, and cascaded to a chronic pain type presentation. During the course of his care, four surgeons, Orthopaedic and Neurosurgeons, have evaluated this patient and have all concluded that this patient needs an operation. ____, who performed the IME, has not proposed the surgery, but the other three examining surgeons have all proposed surgery for this patient. ____, in his frustrations regarding the preauthorization process for Worker's Compensation, has issued a statement that if the carrier continues to deny the proposed surgery, that all outcomes would be the responsibility of the carrier. The fact of the matter is, if surgery is carried out and does not achieve the desired outcome, the patient does not go back to work and cascades into multiple surgeries and/or a variety of pain management modalities, the patient would still be under the responsibility of the carrier. Some authors feel that central protrusions are degenerative in nature, where as eccentric or lateral protrusions are traumatic in nature. At no point has there been a demonstration of a compressive lesion to correlate the MRI findings with EMG and physical exam. A positive discography at L5-S1 was elicited in what was initially felt to be relatively normal disc on the first MRI. This case is

complicated by cascading pain and repeat testing, when the initial test did not reveal the current diagnosis.

As a reviewing physician of medical records, the science of this request is unclear and in the reference to evidenced based medicine, particularly the Gibson-Waddell studies, regarding lumbar fusion to treat back pain. There are other studies that do suggest that early surgery can quicken the outcome and return to work, although ultimately the outcome may be the same regarding surgical and non-surgical modalities. In general principals, the indication for spine surgery are for progressive neurologic deterioration, instability, and/or development of intractable pain. The issues in this case do not appear to be resulting from instability or progressive neurologic deterioration. As a result, it is concluded that the indications are chronic, intractable pain. The Caragee Studies suggest that pain as a finding on discography is not a good predictor of outcome of surgery.

The basic issues here seem to be not the science of this request, but the art. Medicine is both an art and a science. The reviewing physician, both peer review and preauthorization physicians are correct in their analysis regarding their review of the indications of the proposed testing and/or surgeries. The literature is very easy to find support for either stance in regard to scientific studies. Critical information lacking in this case are psychologic evaluations regarding this patient's pain, and/or further scrutiny of pain behaviors where there is multiple trips to the emergency room, etc. There is no report of independent observation and/or unannounced observation, that this patient is restricted as claimed, and there is no report from an examining surgeon that this patient does not need an operation. Therefore, the decision is made in the conclusion that four examining surgeons have recommended surgery, and assuming that the patient is in intractable pain, with a legitimate claim, along with three years of failed efforts for resolution with non-operative measures, it is considered appropriate for a reviewing physician to defer to the examining physicians. The risk, however, of the proposed surgery is that the patient could have a one in ten chance of a serious complication during or immediately after the operation. Use of hardware is a strong underlying factor for the need for subsequent or follow up surgeries. There is a small risk of transitional syndrome where the disc or facet joint would generate pain above a fusion site, and/or below. The outcome of failed surgery is typically worse than the outcome of non-operative backs. The evaluating and/or treating physicians are active in their role as patient advocates according to the Hippocratic oath. The treating surgeon may want to take a closer look at this patient's pain behaviors prior to performing the surgery, to insure there is no psychosocial issues or secondary gain concerns, (Spengler Studies from Vanderbilt) etc.

___ 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 4th day of August 2004.