

July 29, 2004

MDR #: M2-04-1577-01
IRO Cert. #: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Treating Doctor: office notes, consultations, therapy notes, evaluations and radiology reports.

Information provided by Respondent: correspondence

Clinical History:

This patient was injured on ____. He was 60 years old at the time of injury. He developed back pain and was initially treated by a chiropractor. On 5/31/02, he was sent for lumbar MRI, which demonstrated a small, central, inferiorly extruded disc herniation at T12-L1, diffuse disc bulge at L1-L2, facet joint hypertrophy at L2-L3, mild diffuse disc bulge at L3-L4, mild to moderate diffuse disc bulge with annular tear and severe bilateral facet hypertrophy at L4-L5 resulting in mild to moderate central stenosis, and mild diffuse disc bulge and degeneration with facet joint degeneration at L5-S1. The claimant then underwent two epidural steroid injections by on 11/14 and 12/10/02, apparently providing no significant benefit.

On 6/13/02, the claimant was seen for a surgical evaluation. The surgeon documented primarily centralized lumbar pain with occasional radiation to the left buttock. Physical examination demonstrated normal strength in the lower extremities, normal range of motion in the lumbar spine, negative straight leg raising test bilaterally, normal reflexes in the lower extremity, and normal sensation in the lower extremity. The claimant was told that it would take about three months for him to fully heal and "no surgery is needed".

Following that, the claimant was referred for evaluation of a chronic pain management program. Initial psychological testing with the T-3 test demonstrated below average scores in depression and anxiety, indicating that "problems in these areas are minimal and unlikely to interfere with treatment". Nevertheless, the claimant was started in a chronic pain management program, continuing in that program from the beginning of January through the end of February of 2003. The claimant's pain level decreased only from a level 9 to level 6, but he was deemed fit to return to work. In follow-up on 5/5/03, it was documented that he "was actively working full-time without restriction". Depressive symptoms were said to have been resolved. The claimant was taking Bextra, Skelaxin, Vicodin ES q.6-q.8 daily. Physical examination demonstrated negative supine and sitting straight leg raising and no neurologic deficits. Similar findings of continued lumbar pain complaints continued to be documented on 7/1, 9/8, and 12/4/04, except that on 12/4/03 it was documented the claimant had radiating pain to the lower extremities (side not specified). Physical examination, however, on that date did not demonstrate positive straight leg raise, and the claimant was noted to be normal regarding heel-and-toe examination.

The claimant was again referred for surgical evaluation on 1/20/04. The surgeon noted that the claimant had been experiencing bilateral leg pain beginning two weeks after the injury, although the records clearly indicate otherwise. Physical examination demonstrated positive straight leg raising on the left and negative on the right. There was slightly decreased weakness of the left EHL with decreased sensation in the dorsum of the left foot and lateral calf. MRI was recommended.

On 3/4/04, continuing complaints of lumbar pain radiating to an unspecified lower extremity were documented. Physical examination again did not demonstrate positive straight leg raising. Subsequent evaluations on 4/6/04 and 5/17/04 documented left greater than right lower extremity symptoms with positive straight leg raising test on an unspecified side. On 6/28/04, the last documented evaluation, the claimant was no longer said to have lower extremity symptoms, and the physical examination again did not demonstrate the positive straight leg raising test. The request for lumbar MRI has been reviewed and denied as medically unnecessary as related to the work event on at least 4 occasions by different physician advisors.

Disputed Services:

Repeat MRI without contrast.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that a repeat MRI is not medically necessary in this case.

Rationale:

This claimant suffered a lumbosacral sprain, completed epidural steroid injections without relief, and then attended a chronic pain management program despite there being little, if any, evidence of psychologic problems to justify such a program. At the conclusion of the program, he was returned to full duty work at the end of February 2003.

Ten months later, the claimant complained of lower extremity symptoms, but did not manifest any evidence of neurologic deficit, reflex changes, sensory changes, or straight leg raising tests on the evaluation on 12/4/03. Similarly, subsequent visits also failed to demonstrate any signs of radiculopathy, sensory changes, reflex changes, or focal neurologic deficits other than two visits on 4/6/04 and 5/17/04 when only positive straight leg raising tests were noted, but the side of the findings was not.

There is no documented consistent finding of neurological deficit, straight leg raising test, or focal neurologic findings in the notes provided for review. The MRI of May 31, 2002 clearly shows multilevel lumbar degenerative disc disease, lumbar degenerative facet disease, and lumbar spondylosis, all of which are findings consistent with ordinary diseases of life. The claimant was returned to work in February of 2003 without these symptoms.

This claimant has been evaluated by multiple providers with no consistent reproducible exam findings of radiculopathy. Therefore, there is no necessity for a repeat lumbar MRI for further evaluation of treatment of the ___ injury. Repeat imaging studies for the ___ injury, therefore, are not medically reasonable or necessary.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

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 July 29, 2004.

Sincerely,