

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0065-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Dr. S, MD
(Treating or Requesting)	

October 12, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedics. 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,

Medical Director

#### CLINICAL HISTORY

The first entry in the file is an x-ray of the hI and lumbar spine predating the injury, which apparently was performed on 3/25/02. HI x-rays are said to show some possible osteopenia in the femoral head. Lumbar spine x-rays show well-maintained disc space. There was noted to be a possible abnormality at the upper portion of the S1 joint on the left side.

On 8/30/02 Dr. I, family practice physician, saw the patient noting that she had hurt her back at work and had low back pain radiating up to the mid back. She was noted to be obese, weighing 229 pounds, and had muscle spasm in the back. Straight leg raising was unremarkable. No evidence of deficit was noted on neurological testing. Reflexes were intact. The diagnosis was low back strain. The patient was given medications. On 9/6/02 Dr. I saw the patient again with notes that was 25% better, but was still having some back pain radiating down to the thighs. She had no neurological complaints. She had tenderness over L2-3. Straight leg raising was possible to 75° bilaterally. Neurological exam was normal. The impression was low back strain with a recommendation to continue activities as tolerated and consider physical therapy.

On 9/19/02 the patient was seen again with complaints of low back pain without change. She was working, but having problems. It was noted that she had had a history of back problems and that an MRI had shown some bulging at the L4-5 disc in the past. Exam was unremarkable except for some referred pain to the hI area and limited function. Flexion and extension were normal. Physical therapy was prescribed along with medications. On 10/10/02 Dr. I saw the patient again, noting that she had not attended physical therapy yet and was taking Daypro without any improvement. She had tenderness over the lower back and decreased straight leg raising. X-rays of the L-spine were said to be unremarkable. The diagnosis was low back pain and neuropathy. She was referred again to physical therapy and her medications were changed. Lumbar spine x-ray dated 10/11/02 was normal.

Dr. I saw the patient again on 10/14/02, noting that she was not getting any better. Lodine was seeming to help her pain. Exam was unrevealing and she was given some work restrictions and placed on Soma and continued on Lodine and an orthopaedic referral was made on 10/28/02. Dr. I saw the patient again. Exam was unrevealing. The diagnosis was low back strain with neuropathy and a history of spinal stenosis. It was felt that an MRI might be indicated as well as continuation of physical therapy and medications.

On 11/2/02 she had a lumbar MRI scan. There was noted to be minimal generalized bulging of the L4-5 annulus without encroachment on thecal sac and no evidence of a herniated disc.

On 11/25/02 Dr. I saw the patient again, noting that she was in physical therapy and that was making things worse. She had lumbar pain from L1 to L4 on palpation and negative neurological exam. The diagnosis was low back pain with mild bulging disc and again orthopaedic referral was recommended.

She was apparently seen in the emergency room on 11/27/02 with a history of back pain and a history of chronic back pain. Neurological exam was normal. Information is not provided to determine what treatment was rendered.

On 12/6/02 the patient saw Dr. S, orthopaedic spinal surgeon. He noted her history of having injured her back in \_\_\_ and having had physical therapy and medications. She was complaining of tingling in her legs and leg pain on the left side. She was noted to be asthmatic and was a smoker, smoking about 1/2 pack of cigarettes per day. Exam showed normal lumbar flexion and a slight restriction of extension. She was unable to perform heel-walking. Neurological exam was normal. Straight leg raising was negative in a seated position and in a supine position. She had a 5/5/ positive Waddell's sign. He diagnosed lumbar strain and recommended returning to work light duty, obtaining an EMG and nerve conduction study, and continuation of medications.

On 1/7/03 Dr. S wrote a letter requesting EMG and nerve conduction studies.

On 1/30/03 Dr. B saw the patient for another opinion. He felt she has mild radicular and nonspecific low back pain. He noted that she weighed 240 pounds. He felt there was no objective evidence

suggesting that further diagnostic testing was necessary. She showed restrictions on physical work ability testing. She was felt to be capable for sedentary type work.

She was seen again by Dr. B on 3/13/03. She was complaining of dull, aching numbness in both lower extremities. He again felt that she had nonspecific low back pain. He again felt that further diagnostic testing was not necessary. She was felt to be capable of light duty type of work.

On 7/30/03 the patient was seen by Dr. T, PM&R, for a designated doctor evaluation. She complained of chronic, constant lower back pain with radiation into the legs and some pain radiating into the feet with some intermittent numbness and tingling. He reviewed her treatment history and noted that Dr. S had recommended epidural steroid injections and EMG studies. On his exam he noted that was a depressed-appearing, obese female with a slow wide-based gait. She has diminished lumbar range of motion. He noted a normal neurological exam except for the absence of ankle jerks and negative straight leg raising. He diagnosed chronic low back pain status post low back strain complicated by morbid obesity, rule out radiculopathy. He felt an EMG study would be appropriate and possibly a bone scan. He was hesitant to recommend epidural steroid injections. He felt she was not at MMI. He felt that if the studies recommended were negative, then a pain management program might be appropriate as well as weight reduction.

On 10/30/03 she saw Dr. D. He reviewed her history and noted that Dr. S had recommended a lumbar epidural block. His exam revealed tenderness of the lower lumbar segments with positive straight leg raising on the right with normal reflexes and no motor deficits. He recommended proceeding with an L4-5 lumbar epidural block.

On 11/5/03 the patient underwent nerve conduction studies and EMGs of the back and lower extremity. The study was normal with no evidence of lumbar radiculopathy.

On 11/18/03 she underwent a lumbar epidural block at L4-5.

Dr. S again saw her on 8/4/03 and completed a TWCC-73 indicating that she could not work.

On 6/8/04 Dr. T saw the patient again for a designated doctor appointment. Patient was complaining of chronic intractable low back pain, radiating into the legs. She also was now having significant depressive symptomatology with feelings of depression, sadness, helplessness, etc. On exam she had an antalgic gait. She had tenderness in the lower back. Sensory and motor exam was unchanged with no significant deficits noted except for some give way weakness. The impression was chronic intractable low back pain with mild degenerative disc disease. He felt that the underlying problem was a chronic pain syndrome with significant clinical depression. He recommended a comprehensive pain management program. He felt that she was clearly at MMI. He assigned MMI on 6/8/04 with a 5% impairment rating.

On 6/14/04 Dr. S saw the patient again, noting that an MRI showed evidence of stenosis from L4 to S1 and noted that she had had an epidural injection. He noted no motor deficits. He diagnosed spinal stenosis and felt that she was not at MMI and requested discograms at L3-4, L4-5 and L5-S1 and continuation of medications.

On 1/27/04 Dr. T saw the patient again for another designated doctor exam. She was still having back pain, but reported that she had gotten some relief from the first epidural steroid injections. Apparently the subsequent epidurals were denied by the insurance carrier. He subsequently stated that he felt that further epidurals were reasonable, as she had gotten some relief from the first ones and that if they were successful she should enter a work hardening program.

On 7/30/04 Dr. S wrote a letter requesting reconsideration for discograms. He felt that the previous denial was inappropriate, as a reviewer apparently had denied the discography on the basis of no instability being noted. He wished to proceed with discography to diagnose the presence or absence of discogenic back pain.

On 8/10/04 Professor O reviewed the patient's clinical course. It was his opinion that there was no available information from the records of concordance evidence of neurocompression or structural compromise. He felt the discography was unreliable and that there were no indications for spinal fusion. He quoted several sources from the literature indicating very limited improvement with spinal fusion and quoted Fitzler's study in 2001 indicating a minimal difference between patients undergoing lumbar fusion and non-operative patients in terms of pain relief over a period of time. He noted a significant rate of

complications in the range of 17% from fusion surgery. HE also quoted a study by Brox in *Spine*, September 1, 2003, in which patients undergoing lumbar fusion did no better than those who received a lecture on back safety and ordinary activity followed by exercises for three weeks. He recommended that the patient focus on increasing her activity tolerance through conditioning and proceed with a gradual return to work.

Previous review determinations are also reviewed including one on 8/11/04 in which the reviewer felt there was no medical documentation presented which would indicate the need for a lumbar discography.

In summary, claimant sustained a work-related lumbar strain. She appears to have developed a chronic pain syndrome with clinical evidence of depression. Objective evidence including EMG studies and lumbar MRI show only some minimal degenerative bulging of the L4-5 disc. The records also reflect that she may have had a preexisting condition, as referred by Dr. I prior to this injury.

#### REQUESTED SERVICE(S)

Lumbar discogram with CT scan.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

In view of her history of depression and limited structural abnormalities noted on MRI scan and a normal EMG and nerve conduction study, in my opinion this patient is not a candidate for any type of surgery. As noted in Dr. O' review, the benefits of lumbar fusion are very minimal and the surgery itself is associated with a high complication rate, making it illogical to consider surgery for a single, limited minimal discs abnormality on MRI scan in this claimant. The request for discography, presumably, has been made in order to try to diagnose whether or not her L4-5 disc or other discs could be the source of her problems. Discography has been shown to have a very high false positive rate and can also cause the onset of increased low back pain in normal individuals.

Further evidence regarding the difficulty with diagnosing the source of pain with discography is available from an article by Carragee in *Spine*, June 1, 2000. In this article he noted that 10% of pain-free

individuals reported pain with discography and 83% with individuals with a somatization disorder had painful injections. This claimant certainly appears to have psychological abnormalities, which would suggest that discography would be very unreliable in identifying the source of her pain. In his article, Carragee indicates that the rate of false positive discography may be low in patients with normal psychometric profiles and without chronic pain. This claimant would not meet that criteria, therefore it would be unlikely that discography would be accurate in diagnosing the source of her pain. Further evidence regarding limited effectiveness of discography is present in an article by Dr. Gee in *Spine*, December 1, 1999. He concludes that the ability of patients to separate spinal from nonspinal forces of pain on discography is questionable and that a response of concordant pain may be less meaningful than often assumed.

## 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 13<sup>th</sup> day of October, 2004.

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

Printed Name of IRO Employee: