

December 16, 2004

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT  
EMPLOYEE:  
POLICY: M2-05-0420-01  
CLIENT TRACKING NUMBER: M2-05-0420-01/5278

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Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

**Records Received:**

Records from the State:

Notification of IRO assignment dated 12/3/04, 1 page  
Letter from Texas Workers' Compensation Commission dated 12/3/04, 1 page  
Medical dispute resolution request/response, date received 11/12/04, 4 pages  
Letter from Texas Mutual Insurance Company dated 10/19/04, 2 pages  
Letter from Texas Mutual Insurance Company dated 11/2/04, 2 pages

Records from Requestor:

Request for additional external review case information dated 12/3/04, 1 page  
Letter from Texas Mutual Insurance Company dated 10/19/04, 2 pages

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Letter from Texas Mutual Insurance Company dated 11/2/04, 2 pages  
Letter from Texas Workers' Compensation Commission dated 11/16/04, 1 page  
Medical dispute resolution request/response, date stamped 11/2/04, 5 pages  
Telephone conference note dated 11/4/04, 1 page  
Orthopedic report dated 10/7/04, 3 pages  
Letter from \_\_\_ dated 7/6/04, 3 pages  
TWCC-69 report of medical evaluation dated 6/2/03, 1 page  
Designated doctor examination report dated 6/2/03, 4 pages  
Letter from Texas Workers' Compensation Commission dated 10/31/02, 1 page  
Letter from Texas Workers' Compensation Commission dated 10/9/02, 1 page  
TWCC-69 report of medical evaluation dated 6/24/02, 1 page  
Designated doctor examination report dated 6/24/02, 6 pages  
Office note dated 7/24/01, 1 page  
Office note dated 5/29/01, 3 pages  
Office note dated 3/13/01, 1 page  
Office note dated 1/9/01, 1 page  
TWCC second opinion spine surgery report dated 3/6/01, 3 pages  
TWCC results of examination dated 3/6/01, 1 page  
TWCC results of examination dated 2/22/01, 2 pages  
Initial medical report dated 2/13/01, 2 pages  
Letter from The Texas Fund dated 1/29/01, 1 page  
Letter from Texas Workers' Compensation Commission, received date 1/26/01, 2 pages  
Letter from Dr. Graham dated 12/7/00, 1 page  
Office note dated 11/1/00, 1 page  
Office note dated 10/23/00, 2 pages  
Office report dated 10/7/04, 3 pages  
Lumbar myelogram report dated 9/10/01, 1 page  
CT scan report dated 9/10/01, 1 page  
Office report dated 2/16/01, 1 page  
Electromyography report dated 2/16/01, 1 page  
Nerve conduction study report dated 2/16/01, 1 page  
MRI report dated 1/4/01, 2 pages  
MRI report dated 10/26/00, 2 pages

Records from Respondent:

Letter from Texas Mutual Insurance Company dated 10/19/04, 2 pages  
Letter from Texas Mutual Insurance Company dated 11/2/04, 2 pages  
Orthopedic report dated 10/7/04, 3 pages  
Office note dated 8/2/04, 1 page  
Emergency physician record, undated, 2 pages  
TWCC-69 report of medical evaluation dated 6/2/03, 1 page  
Designated doctor examination dated 6/2/03, 4 pages  
Office note dated 5/6/03, 1 page  
Office note dated 4/24/03, 1 page  
Office note dated 4/4/03, 1 page

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Office note dated 2/14/03, 1 page  
Lumbar myelogram report dated 9/10/01, 1 page  
CT scan report dated 9/10/01, 1 page  
Office report dated 2/16/01, 1 page  
Electromyography report dated 2/16/01, 1 page  
Nerve conduction study dated 2/16/01, 1 page  
MRI report dated 1/4/01, 2 pages  
MRI report dated 10/26/00, 2 pages

**Summary of Treatment/Case History:**

The patient is a 40-year-old female who developed sudden back pain after lifting a box at work on \_\_\_\_\_. Dr. Marshall evaluated the patient on 10/23/00 with progressively worsening pain and stiffness. She had low back pain radiating into both hips to the toes on the right, going down the posterolateral aspect of the foot. She had a prior L4-5 discectomy in 1986. He was taking hydrocodone, ibuprofen, and Tylenol. The examination revealed a slow, antalgic gait to the right, positive sitting and supine straight leg raises on the right and a positive cross over test on the left. Sensation was intact in fine touch throughout all dermatomes, with the exception of S1 on the right. She was sore from L3 to sacrum both left and right, and was tender in the sciatic notch. Forward flexion was approximately to 30 degrees with moderate pain and inability to hyperextend due to pain. X-rays were reportedly normal. She was diagnosed with a probable reherniation. An MRI, physical therapy, and Vicodin were recommended.

An MRI of the lumbar spine performed on 10/26/00 revealed an unenhancing broad-based bulge from the posterior margin of the L5 disc, indenting the anterior spinal theca. This had the appearance of a bulging disc and did not show any enhancement to suggest scarring.

On 11/1/00 Dr. Marshall recommended epidural steroid injections.

Dr. Graham took over the patient's care and evaluated her on 12/7/00 with low back pain radiating into the buttocks and down both legs, as well as numbness and tingling and weakness in both legs. She had positive root tension signs bilaterally, worse on the left, weakness of the left extensor hallucis longus muscle and of the left ankle dorsiflexion when compared to the right side. She walked with an antalgic gait. She was diagnosed with radicular pain affecting both legs and a possibly progressive neurological deficit. A repeat MRI, activity restrictions, off work and possible laminotomy and discectomy were recommended.

An MRI of the lumbar spine dated 1/4/01 revealed: 1) large, extruded posterior-central disc hernia at L5-S1 which had not significantly changed compared with the prior exam dated 10/26/00; disc mildly stenoses the central spinal canal, indents the ventral aspect of the thecal sac and slightly compresses both right and left S1 nerve roots; 2) a smaller posterior disc hernia at L4-5, also stenoses of the central spinal canal, compressing the thecal sac and both L5 nerve root, stable to slightly worsened compared with October, an old right laminectomy defect; 3) facet arthritis, greatest at L5-S1 on the left, moderate degenerative neural foraminal stenosis on the left at L5-S1, with bulging disc and lateral osteophytes abutting the left L5 nerve root; and 4) lumbar muscle spasm.  
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On 1/9/01 Dr. Graham noted that the leg pain was worse than the back pain. She had no improvement. Laminotomy and discectomy were recommended as a possible emergent procedure if worsened.

An IME of 2/13/01 noted mechanical low back pain with underlying restrictions due to myofascial strain and radiating symptoms to both lower extremities. She was unable to perform any occupational duties.

Dr. Ramzy, neurologist saw the patient on 2/16/01 for EMG studies. She was using a wheelchair, as her legs were getting weaker. The examination showed severe paralumbar muscle spasm, bilateral positive leg raise at 30 bilaterally, equal and brisk deep tendon reflexes, but measurable diminution of both ankle jerks. She had sensory deficit distribution of overlapping dermatome L5-S1 on the left side. The EMG showed evidence of bilateral S1 nerve root irritation and left L5 radiculopathy. She was diagnosed with multiple posttraumatic lumbar radiculopathies, predominantly distribution of bilateral S1 and left L5. She was given Vicoprofen and Flexeril. She was to continue chiropractic treatments and to see Dr. Berliner and consider epidural steroid injections in the future.

The patient saw Dr. Berliner on 3/6/01 for a second opinion regarding spine surgery. She reported some relief with physical therapy, but had difficulty getting to appointments. She had an absent Achilles reflex on the left and a diminished one on the right, a slow antalgic gait, diminished sensation in the right S1 dermatome completely with diminished sensation on the left, a positive straight leg raise bilaterally, although more significantly on the left as this caused leg pain down to her foot, weakness in motor strength and tenderness in the lumbar spine. She was diagnosed with herniated nucleus pulposus L5-S1, recurrent herniated nucleus pulposus L4-5. Additional conservative care with physical therapy, NSAIDS, possible epidural steroid injections were recommended prior to surgical intervention.

The patient saw Todd Briggs, PA on 3/13/01 with a mildly positive straight leg raise, hyper-reflexia in her patellar reflexes and a 1+ reflex in her Achilles and 4/5 motor strength. She was to start amitriptyline and aqua therapy and lumbar corset. She denied paresthesia. She had some relief with aquatic therapy.

She saw Dr. Bahrani on 5/29/01 with complaints of pain over the coccyx and lumbosacral spine, occasional tingling sensation during her period, no weakness, increased pain with coughing and sneezing and sitting. She had moderately restricted range of motion, diffuse tenderness in the area of the previous scar, and tightness of the hamstrings with straight leg raise. She was diagnosed with recurrent herniated nucleus pulposus at L5-S1 and facet arthropathy, possible spinal stenosis.

She was referred for a second opinion with a spine surgeon, however on 7/24/01 she had still not done this due to lack of transportation. Physical therapy was discontinued due to her large extruded disc in her spine. Ultram and Skelaxin were recommended.

A lumbar myelogram dated 9/10/01 revealed large disc herniation at L4-5 with a possible disc herniation at L5-S1. A CT showed centrally extruded disc herniation at the L4-5 significantly

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compressing and displacing the dural sac, and increased soft tissue density at L5-S1, which could represent extensive scar formation and/or disc herniation.

The patient was seen on 6/24/02 by Dr. Simonsen for a DDE. It was noted that Dr. Torres, neurosurgeon, recommended discography on 8/21/01, but it was not noted if this had been done. She reported constant low back pain with radiation into both buttocks constantly in her lower back with radiation into both buttocks and slight tingling in the right leg, worse with bending, twisting, and standing more than 45 min and painful Valsalva maneuver, and pain with sitting and driving. She had no injections yet. The examination noted a satisfactory gait, but complained of increased pain when walking on toes and heels. She had a mildly flexed posture, minimal tenderness of lumbar spine and it was nonfocal, deep tendon reflex 2+ at knees and 1+ at ankles, mild decreased ROM. McKenzie evaluation for mechanical features identified pain in her lower back that was not severe and made worse with repeated flexion, however, no radicular pain was created. She had difficulty lying prone, but that position was able to do repeated extension maneuvers in lying, did centralize her pain, and was no worse. She appeared to be a directional performance that needed further evaluation. She was diagnosed with lumbosacral discogenic pain. Additional conservative treatment was recommended, including extension of program regularly. Maximum medical improvement was expected on 10/11/02.

Dr. Simonson on 6/2/03 noted muscle spasm in lower back, occasionally radiating into her calves, relieved with soma, tingling in both legs and numbness in the fourth and fifth toes into the right foot, no weakness, moderately painful Valsalva with back and leg pain. She could walk well on her heels and toes, was hesitant on heels due to increased pain, had weight loss, had minimal tenderness to palpation of lower back, 1+ deep tendon reflexes, normal appearing strength, moderate loss of sensation in the S1 distribution on the right side and that incidentally would likely not be from her surgery in 1986 because that was at the L4 level, moderately decreased range of motion part in flexion, major loss of flexion, pain with movement, worse with repeated flexion, moderate central pain with repeated extension in standing and lying but part lying, and was not yet doing full extension. She centralized her pain with repeated extension, but not completely obliterated the S1 radicular symptoms. Maximum medical improvement was 10/11/02 with whole person impairment of 10 percent.

The patient saw Dr. Berliner on 10/7/04 with complaints of 8/10 back pain radiating mostly into her right lower extremity, but felt it in both. She had brisk patellar reflexes bilaterally, but Achilles reflex was 1+ or trace on the right and 2+ on the left, a positive straight leg raise bilaterally, motor weakness in the right foot evertors compared to the left, weak extensor hallucis longus bilaterally, diminished sensation along the right L5 dermatome and bilateral S1 dermatomes. Hydrocodone, soma, and anti-inflammatories were refilled. A lumbar laminectomy at L4-5 and L5-S1 was recommended.

**Questions for Review:**

Please address prospective medical necessity of the proposed L4/5 revision decompression (#63042), L5/S1 revision decompression (#63042), regarding the above-mentioned injured worker.

**Conclusion/Decision to Certify:**

The proposed L4-5 revision decompression (#63042) as well as the L5-S1 revision decompression (continued)

(#63042) appear to be medically necessary. The rationale is that the patient has undergone prior surgery, but has had continued complaints of pain despite extensive conservative measures. Neuroradiographic imaging confirms neural compression at both the L4-5 and L5-S1 levels, at the foraminal level. She has evidence of a disc herniation with concomitant stenosis; at L5-S1 there is evidence of recurrent disc herniation as well as stenosis. Due to her failure to respond to conservative treatment, as well as positive findings noted on neuroradiographic imaging, the planned procedures do appear to be medically necessary and reasonable. She has failed extensive conservative treatment, and the diagnostic studies show evidence of nerve root compression.

**Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:**

Orthopedic Knowledge Update: Spine, 2, Chapter 34, pages 328-330.

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The physician providing this review is board certified in Orthopaedic Surgery. The reviewer is a member of the American Academy of Orthopaedic Surgeons, the American Medical Association, the North American Spine Society, the Pennsylvania Medical Society, the Pennsylvania Orthopaedic Society, the American Association for Hand Surgery and is certified in impairment rating evaluations through the Bureau of Worker's Compensation. The reviewer has publication experience within their field of specialty and has been in private practice since 1995.

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

**YOUR RIGHT TO REQUEST A HEARING**

Either party to the 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 receiving the TWCC chief Clerk of Proceedings within ten (10) days of your receipt of this decision as per 28 Texas 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 as per Texas Admin. Code 102.4 (h) or 102.5 (d). A request for hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
POB 40669  
Austin, TX 78704-0012

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

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It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

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The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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CC: Dr. Berliner  
Texas Mutual