

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0432-01
Name of Patient:	
Name of URA/Payer:	American Home Assurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. U, DC

January 7, 2005

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

cc: Rebecca Pope
Dr. U, DC
Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

The first group of medical records includes an MRI of the lumbar spine dated 9/27/02 done in Dallas, Texas. This MRI shows mild facet arthropathy at L4-5 with mild ligamentum hypertrophy and central and right paracentral disc protrusion at L5-S1 extending into the lateral recess. There was noted to be some mass affect on the S1 nerve root. Mild disc desiccation and degenerative changes were also shown at L5-S1.

On 1/13/03 the patient underwent operative treatment of her lower back. The preoperative diagnosis was herniated L5-S1 disc with right S1 radiculopathy. The patient underwent a hemilaminectomy at L5-S1 on the right with limited right S1 foraminotomy and disc excision using microscopic technique by Dr. C.

On 5/10/03 the claimant underwent another MRI of the lumbar spine done at Baylor University in Dallas. There were noted to be equivocal findings for arachnoiditis. There was noted evidence of recent lumbar surgery with a right hemilaminectomy at L5-S1 with some enhancement along the posterolateral margin of the L5-S1 disc compatible with a partial discectomy and some granulation tissue along the surgical tract on the right side. No recurrent disc was noted. The uterus was noted to be enlarged with evidence of fibroid tumors.

On 1/6/04 a designated doctor exam was done by Dr. S. He reported a history of the patient having been working as a nurse when she injured her back and having had back surgery by Dr. C. She was still complaining of back pain with numbness and weakness and tingling. It was also noted that she had had fibroid tumors and had subsequently had a hysterectomy in June 2003. On exam she had tenderness in the lower back and difficulty with toe walking with a positive straight leg raising. It was felt that since she was scheduled to receive steroid injections and had started a pain management program that she was not at MMI. He stated that if she had continued

pain another MRI should be done to check for a recurrent disc herniation.

On 2/2/04 another MRI of the lumbar spine was performed. This showed a 3-mm focal right lateral recess discal protrusion at L5-S1 with mild indentation of the thecal sac and some posterior displacement of the right nerve root sleeves. On 3/24/04 she had a lumbar myelogram and post-myelogram CT. The myelogram showed a minimal anterior extradural defect at L5-S1 without significant compression of the thecal sac. She had conjoined right L5 and S1 nerve root sleeves with normal filling. The left S1 sleeve was unremarkable. Post-myelogram CT showed evidence of a previous right laminotomy with a shallow right paracentral disc bulge, but with normal filling of the right S1 nerve root sleeve. The spinal canal and neural foramina were widely patent. L4-5 and L2-3 levels were normal.

On 8/11/04 Dr. U wrote a letter indicating that the patient's condition had failed to improve after the laminotomy and that the patient was unhappy with her prior surgeon and the patient was being referred to Dr. M.

On 9/14/04 the patient saw Dr. M. He reported that she was complaining of lower back pain and right leg pain with some referred pain to the left leg. He noted that she had injured her back lifting a patient and had onset of back pain on 8/23/03 and had not worked since October 2002. He noted that she had had a previous surgery by Dr. C with little alleviation of her right leg pain and gradual increase in pain in her leg and her back over time. She complained of numbness in her legs, the right side being worse than the left. She did not note any weakness or bowel or bladder dysfunction. She had received an epidural steroid injection, which had not helped here. He noted that she had had a lumbar myelogram CT, which confirmed a right L5-S1 laminotomy but did not confirm a new specific disc. He also reviewed the MRI done February 2004 and an MRI done 5/10/03. It was noted that she was taking Robaxin, Flexeril, Darvocet N100, and Neurontin.

New X-rays of the lumbar spine were taken, showing some narrowing of the L5-S1 disc space with slight retrolisthesis at the L5 vertebral body in relation to S1. He felt the MRI scans showed significant disc desiccation at L5-S1 with probably granulation rather than a disc herniation. Myelogram revealed good nerve root sleeve filling. His assessment was that the patient had a degenerative postoperative L5-

S1 disc. He noted that the pain had increased after surgery and she had a poor functional state. He recommended consideration for an L5-S1 instrumented fusion to treat her degenerative L5-S1 disc. Physical exam on that date demonstrated some spasticity of the lower extremities. She had lower back pain with straight leg raising. She had decreased sensation in the right foot and negative clonus and Babinski. Motor strength was intact. Reflexes appeared to be absent at the knee and ankle on both sides.

On 9/21/04 Dr. M submitted a request for authorization for surgery for posterior lumbar interbody fusion and lateral fusion of L5-S1 using cage implants, pedicle screws and rods, and bone morphogenic protein.

Subsequent additional medial records indicate that the patient was treated at the Associated Physical Therapy Clinic. She apparently was also treated postoperatively by Dr. D. The handwritten notes are difficult to interpret, but she was apparently referred for work hardening and placed on Mobic and Vicodin on 10/30/03. He continued to follow her in November 2003 with continued complaints of lower back pain. The diagnoses on these encounters were failed back. On December 16, 2003 he apparently referred her for four more weeks of physical therapy and continued Mobic and Vicodin.

Functional capacity evaluation was apparently completed by ____, PT, date uncertain. The patient was found to be able to perform light to medium work and a pain management program was recommended.

On 11/18/03 Dr. K performed a medical record review. He noted that her course had followed a somewhat typical pattern for her operative diagnosis. He felt that the documentation supported the initial and subsequent diagnoses. He noted that an MRI dated 9/27/02 showed degenerative disc disease and degenerative facet joint changes prior to her injury, possibly predisposing her to a disc herniation.

On 12/9/03 the patient underwent an EMG and nerve conduction study. The handwritten notes are difficult to interpret; it is hard to determine the physician's name. His impression was evidence of a right acute/chronic L5-S1 radiculopathy with no acute denervation. It appeared more chronic than acute. She had normal left lower extremity EMG study.

Subsequent Dr. K, physiatrist, reviewed the EMG studies on 12/22/03. He noted that all of the EMG activity appeared normal and thus the conclusion of acute/chronic radiculopathy was not justified by the data presented.

On 2/25/04 the patient saw Dr. W, a neurosurgeon in Dallas. Her neurological exam was felt to be non-impressive, but she was still complaining of a lot of pain. He recommended an MRI scan, which had been done. The report showed a 3-mm protrusion lateralizing to the right. Straight leg raising was equivocally positive at 60°. Reflexes were hypoactive, but equal. There were no pathological reflexes or sensory abnormalities. He diagnosed post-laminectomy syndrome at L5-S1 and recommended reviewing her films.

A Dr. E also saw the patient in March 2004. He handwritten notes indicate that the assessment was failed low back surgery and he recommended orthopaedic follow up.

On 3/10/04 Dr. W saw the patient again. He noted that she was 5'2" and weighed 200 pounds with a positive straight leg raising on the right at 60-70°. Reflexes were hypoactive and equal. He recommended a weight bearing lumbar myelogram.

On 3/24/04 the patient apparently had a myelogram. Dr. W reviewed the myelogram. He noted it showed a previous right foraminotomy and laminotomy with a shallow right-sided disc bulge, but no evidence of nerve root compression on the weight bearing lumbar myelogram. He felt there was no indication for any neurosurgical treatment and recommended noninvasive pain management and follow up with Dr. U. Dr. E apparently continued to see her in May and June 2004.

There are records indicating that she was seen in the emergency room for a left wrist and hand injury on 12/15/03 unrelated to her back problem.

Subsequent records indicate that the patient had several computerized range of motion tests and other evaluations by Dr. L, a chiropractor, with a diagnosis of lumbar intervertebral disc syndrome, lumbar nerve root injury, muscle spasm, and myofasciitis. The goals for a chronic pain management program were outlined.

On 6/7/04 Dr. L noted that she was having persistent pain in the lower back and had been treated at that clinic since 12/18/03. Neurological

testing revealed normal reflexes, sensation, and motor function with a Lasag sign that was positive on the left at 65° and positive on the right at 54°. She had no atrophy in either lower extremity. On 7/20/04 he saw her again with complaints of soreness and tightness in the lower back and numbness in the right leg. Subsequent notes indicate that she was treated at the Work Accident Clinic in the early part of 2004 with apparent chiropractic treatments with manual therapy. Treatment apparently continued into July 2004 with biofeedback treatments as well. Dr. U continued to follow her and on September 10, 2004 indicated that she had been aggravated by having an injection. She again recommended a referral to Dr. M. On 9/15/04 she noted that the patient had seen Dr. M who recommended surgery. On 10/4/04 the patient presented to Dr. U noting that she had been denied in terms of having surgery authorized and was feeling very frustrated.

On 10/22/04 Dr. U completed an impairment rating indicating clinical MMI on 10/22/04 with a 5% impairment rating related to her lower back problems.

On 9/24/04 Dr. Y made a review determination. It was his opinion that surgery was not indicated for the lower back problem, as there was no evidence of neural compromise on the CT myelogram and no evidence of segmental instability to warrant a fusion. He noted there was no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis. On 10/12/04 Dr. M again requested authorization for surgery for the lower back.

On 10/25/04 Dr. N performed a review determination. He reviewed medical records. He noted that the patient had chronic pain in the back and the leg with a normal neurological exam. He noted there was no evidence of instability and no confirmatory EMG and nerve conduction studies and the patient was noted to have depression. He again referred to ACOEM Guidelines regarding lack of scientific evidence regarding surgical intervention for lumbar spondylosis. He felt that based on the documentation provided that the surgery was not medically reasonable or necessary. He also discussed this with Dr. M.

REQUESTED SERVICE(S)

The requested services are instrumented lumbar fusion with cage implants, pedicle screws and rods, and bone morphogenic protein for the L5-S1 discs level.

DECISION

Denied. The medical records do not substantiate the medical necessity of an L5-S1 fusion.

RATIONALE/BASIS FOR DECISION

This patient has had appropriate treatment for the initial small disc herniation, which she had at the L5-S1 level with decompression, laminotomy, and foraminotomy. Subsequent imaging tests have shown no significant evidence of recurrent disc herniation or significant neurological impingement at the L5-S1 level. There is no documented evidence of lumbar instability. There is no documentation of any neurological deficits on physical exams. There is no documentation of neurological deficits on EMG and nerve conduction studies according to Dr. B's review of the EMG study, which he apparently felt was normal.

The patient appears to suffer from degenerative lumbar spondylosis with a degenerative L5-S1 disc. There is evidence in medical literature to suggest that fusion for spondylosis is not effective. An article by Ivar Brox et al. September 1, 2004, published in *Spine* found that lumbar fusion did no better than a lecture about safety of ordinary activity followed by exercise three times per week. The surgical fusion group was found to do no better than the non-operative group in residual pain and other outcome measures. It was the conclusion of that author that the risk of complications from surgical fusion did not justify surgery in those patients. Further reliable evidence in the medical literature comes from Fitzler Volvo Award-Winning Study in 2001, which found minimal improvement with fusion versus non-operative treatment with only a 15% difference at two years post-op of operative versus non-operative patients. It was further noted that the 15% difference in improvement between the operative and non-operative group should be compared to a 17% surgical complication rate from the fusion surgery. It was the opinion of that author that fusion in these circumstances was not medically reasonable.

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 11th day of January, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: