



Specialty Independent Review Organization, Inc.

June 16, 2005

TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-1740-01
IRO #: 5284

Specialty IRO 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 Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty 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.

This case was reviewed by a licensed Medical Doctor with a specialty in Neurology. The reviewer is on the TWCC ADL. The Specialty IRO 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 Specialty IRO 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

Ms. ___ had a history of a lumbar discectomy performed at L5-S1 in 1994. She was employed at a large retail store when she suffered an on the job injury on ___. According to the records submitted, she was standing on a ladder when the ladder went off balance causing her to fall and sprain her right ankle and injure her lower back and left lumbar region. Records from Methodist Health Care Emergency Room, dated February 02, 2004 indicate that she was stepping down on the ladder and heard her ankle pop and then hit her tailbone on the concrete. She complained of severe pain in her right ankle. In the emergency room, she had x-rays of her lumbar spine, which showed "an old L1 fracture", but at that time she did not complain of any pain at that site. She was told to use crutches and put ice on her ankle and elevate it and use heat on her back. She was also prescribed Naprelan and Flexeril. Unfortunately, the ER records were not typed. ___ did file an injury report with her employer.

She was seen on ____, the day after her accident, by Dr. Baxter from the Alamo City Medical Group. She reported to Dr. Baxter that she fell off a step ladder at work on February 02, 2004 twisting her right ankle, landing on her buttocks, hitting the back of her head but had no loss of consciousness. The examination showed mild swelling and heat of the anterior tibia and fibular area, the dorsum of the foot and the back of the 5th metatarsal. He recommended light duty and he would review her radiology reports.

She was seen again on February 11, 2004 and complained of left lower lumbar and gluteal area pain radiating to the left hip. Her ankle and foot swelling was better. Her examination showed no radicular signs or symptoms. X-rays showed rotoscoliosis, transitional type vertebrae, and bilateral sacralization through anomalous joints and an L2 lumbar vertebrae. She was maintained on light duty.

She returned on March 03, 2004 and was feeling better. She was going to physical therapy. She was progressing in regard to her back. Her ankle pain was minimal. She was no longer using Vicodin, but was continuing on Naprosyn. She was to remain on light duty. On March 08, 2004 she complained to Dr. Baxter that she was having increasing pain with walking, standing, and pain radiating down the left leg, occasionally as far as the calf. She was tender in the left lumbosacral area, but had no radicular signs or symptoms. He suggested referral to orthopedics for possible lumbosacral pseudoarthrosis.

On March 19, 2004 Dr. Baxter reported that she was improved, but still symptomatic with lumbosacral area pain and tenderness and some radiation to the left leg. She was then referred to Dr. Garcia, an orthopedic specialist. On April 08, 2004 Dr. Baxter wrote that her range of motion was still somewhat protective. She had no radicular signs or symptoms, but complained of lumbosacral area pain with weight bearing. On October 18, 2004 she had had worsening pain over the prior 5 days. A bone scan was ordered to rule out pseudoarthrosis at the SI joint.

Dr. Baxter completed a return to work certificate on October 20, 2004 indicating she could stand for one hour a day, walk for one hour a day, with a 10-pound weight restriction. She was to have a sitting and stretch break 3 times an hour. He did not limit her hours. On October 28, 2004 he stated that all of her studies were so far negative. Dr. Baxter had released her after her EMGs were normal. He stated "currently we are treating her subjective symptoms only and explained to her the reason for release". He completed a release from on February 02, 2004 indicating no restrictions. However, on April 08, 2004 he wrote that she was to be limited to standing and walking to 2 hours a day. No further notes were submitted from Dr. Baxter.

Records from Dr. David Hirsch, a pain management specialist indicated an initial evaluation on April 26, 2004. She reported pain in her lower back, left hip and left posterior thigh. Bending, twisting, sitting and walking and lifting made the pain worse. Heat and medications reduced the pain. She stated that "activities of daily living were not limited secondary to the above noted changes". The examination was normal except for a positive straight leg raise on the left at 45 degrees and positive Faber's on the left and negative piriformis stretch signs. She had pain over the left SI joint and "ropiness" and tenderness in the left gluteus meatus region. His impression

was left SI joint dysfunction, myofascial pain and he wanted an MRI of the lumbar spine. He recommended Zanaflex, stretching and neuromuscular stimulation. He also performed SI joints and trigger point injections into the left piriformis. Initially, these were successful and were repeated on February 02, 2004.

At a follow-up with a physician's assistant on July 21, 2004 she reported that the second set of injections was not that helpful. Dr. Hirsch then recommended additional trigger point injections and weight restrictions of 10 pounds and continuation of Naprosyn and Zanaflex. He saw her again on October 05, 2004 and restarted Zanaflex plus an EMG and nerve conduction studies. These were normal. There was no evidence of radiculopathy. On December 13, 2004 he noted that she was in constant pain and had low back pain, left groin pain and left hip pain. She had seen Dr. James Simmons who felt she had SI joint dysfunction and he was sending her for physical therapy. She was neurologically intact and was at full duty. He then released her from his care.

___ was seen by Dr. Frank Garcia, an orthopedist, on March 25, 2004 approximately ___ weeks after her accident. He noted on examination that she had tenderness over the left SI joint and left paraspinal muscles. She had forward flexion to about 35 degrees and extension was normal. She had tight hamstrings. Dorsiflexion internal rotation accentuated her pain and caused shooting pain down her left leg. Neurologic examination was intact. Patrick's test and Faber's test were positive. His impression was axial strain of the lumbosacral spine and possibly a strain of the SI joint. He recommended an injection over the SI area. Unfortunately, this was not effective. He saw her again on April 20, 2004 and reviewed an MRI of the lumbar spine, which showed no evidence of enhancement or disk protrusion or stenosis and was thought essentially normal. He then continued ___ on light duty. Her also reviewed flexion and extension views of the lumbosacral spine, which showed movement centered at the L4-5 level with some slight retrolisthesis, but not to the degree that she met criteria for instability. There was also evidence of an old tear drop fracture at the superior endplate of L1.

___ was evaluated by a second orthopedist, Dr. James Simmons Jr. Dr. Simmons was the surgeon who performed her lumbar discectomy at L5-S1 in 1994. The date of her initial visit was December 02, 2004. This was approximately 10 months after her accident. He noted on examination that she had tenderness to palpation of the left SI joint and very slight weakness of the left EHL and some mild paravertebral muscle-spasm tenderness. His impression was post-traumatic left SI joint dysfunction, status post discectomy at L5-S1 and radiculopathy left lower extremity, clinical. He recommended physical therapy, Medrol dose pack and Celebrex. When she returned on December 25, 2004, she had switched physicians through the Texas Worker's Compensation Commission. Her pain was continuous radiating down the left leg and thigh primarily. He recommended continued physical therapy and continued off work status. She returned on January 25, 2005 and was essentially unchanged. He agreed with a previous recommendation from Dr. Hirsch for referral to a comprehensive pain management program. On March 25, 2005 Dr. Simmons dictated a memo indicating that an impairment rating had been given to ___ by Dr. William T. Green of 5 percent impairment. He agreed with this finding. On

April 05, 2005, her complaints and exam were unchanged. He again suggested that she to a multidisciplinary pain program and that she was not a surgical candidate.

A functional capacities evaluation was performed on ___ on February 08, 2005. Functionally, she was able to perform a one-time maximal floor lift of 20 pounds and reported increased pain symptoms, tolerating less than 10 minutes walking, less than 10 minutes standing. She demonstrated limited ability to push and pull and was limited with her tolerance of reaching with lightweight (2 pounds) and limited tolerance of overhead work with no resistance. Her cardiovascular fitness category was "very poor" and based on MVE protocol and isometric strength testing, her efforts appeared to be valid. The validity tests included grip strength testing and isometric strength testing.

A workers compensation consultation was performed on February 04, 2005 at the Bethesda Therapy Center by Stephanie Prado, MD. Dr. Prado recommended repeat electrodiagnostic testing and to continue conservative management. It is not clear that ___ returned to see Dr. Prado again, as there are no further notes submitted.

A required medical examination was performed on ___ by Dr. William T. Green on March 15, 2005. Dr. Green noted on examination that range of motion of the spine was attempted but limited by the examinee's self-restriction and suboptimal effort. There was moderate tenderness over the left SI joint and straight leg raise was negative to 70 degrees bilaterally, but limited by some pain on the left. Strength and reflexes were normal. The examinee stated that she had no sensation of the left foot, which was not physiologic and followed no dermatomal pattern. There were no clinical signs of radiculopathy and there was no evidence of muscle atrophy over the lower extremities.

He also reviewed a video taped surveillance dated September 28, 2004, which showed the examinee loading equipment into a boat, walking with a normal gait entering and exiting a pickup truck without apparent difficulty, driving the boat off the trailer, rotating left and right, bending and flexing to approximately 80 degrees and driving the boat at accelerated speeds over fairly rough water. He wrote: "This was inconsistent with the symptoms demonstrated and effort given during this evaluation". He gave her a 5 percent impairment rating using DRE category 2 lumbar tables and an impairment rating of 0 percent with no clinical evidence of radiculopathy or neuromotor loss. She scored a 29 on a Beck's impression inventory and a 31 on Beck's anxiety inventory.

X-rays submitted include a lumbar spine AP and lateral dated February 02, 2004, which showed anomalous lumbosacral junction with degenerative findings in the anomalous articulations and associated facet joints, slight rotoscoliosis, limbus type deformity of L1 with associated degenerative change. Ankle AP and lateral with an oblique February 02, 2004 normal, foot AP and lateral with one oblique of the right February was normal. An MRI of the lumbar spine March 16, 2004 was normal. MRI of the lumbar spine without enhancement June 22, 2004 showed suspected transitional vertebrae at the lumbosacral junction. At L1-2, there was moderate disk space narrowing and decrease of signal on T2 weighted images consistent with disk desiccation. There were marginal anterior osteophytes and mild loss of disk height of the

superior aspect of L2 anteriorly, possibly due to an old wedge compression fracture. There was no bone marrow edema suggesting any acute lesion. There was no spinal stenosis. There was no evidence of disk herniation. The neuroforamen appeared normal. The remaining levels were normal. A bone scan obtained on November 19, 2004 was normal.

Physical therapy assessment performed at the Preventive Medicine and Rehabilitation Centers on December 07, 2004 by Howard C. May, PT indicated a plan for physical therapy 3 times a week for 4-6 weeks. ___ also received physical therapy through Health South of San Antonio, Texas from February 12, 2004 through July 29, 2004.

An evaluation for a comprehensive pain management program was performed by Andrea Zuflecht, MS, LTC. She also had a psychological assessment by Paula Hernandez, MS, LTC. These assessments were performed at the request of Dr. James Simmons and were performed under the auspices of the Neuva Vida Behavioral Health Associates.

Review of the report from PI solutions, including videotaped surveillance on September 19, 2004 indicated that ___ was walking around a residence, sitting down on the grass, not wearing any assistive or supportive device, walking in a fluid manner. At 12:22 p.m. she was observed loading items into a boat and pickup. She was carrying a rope, small cooler bags, a small cooler, a hand bad and a pole. She climbed into the boat and her husband handed her additional small items. Then she moved objects around inside the boat, tied some objects down with rope and untied other items. She was observed inside the boat for approximately 15 minutes. She then moved small rocks from in front of the tires of the boat weighing approximately 10 pounds and picked them up with one hand. She was observed entering the boat where she sat while her husband loaded up items from the pickup into the boat. She then operated the boat and traveled away from the trailer and towards the dock.

RECORDS REVIEWED

1. Employer's first report of injury or illness – 02-02-04.
2. Emergency room record North East Methodist Hospital – 02-02-04.
3. Office progress notes, work status reports, and return to work certificates, N. Baxter, MD – 02-03-04 to 11-10-04.
4. Office progress notes and procedure notes, and workers status report, David M. Hirsch, Do – 04-26-04 to 12-13-04.
5. Office progress notes and work status reports, Frank Garcia, MD – 03-25-04 to – 04-20-04.
6. Office progress notes and works status reports, James W. Simmons Jr., MD – 12-02-04 to 04-05-05.
7. Functional capacities evaluation, Snodden Orthopedic and Occupational Rehabilitation, Scott Summers, PT – 02-0-8-05.
8. Workers compensation consultation Bethesda Therapy Center Stephanie Prado, MD 3-22-05.
9. Designated doctor evaluation, William T. Green, MD – 03-15-05.
10. Multiple miscellaneous x-rays, North East Methodist Hospital – 02-02-04.
11. MRI of the lumbar spine – 03-16-04, 05-22-04 and a bone scan 11-19-04.

12. Physical therapy evaluation and plan of care, The Preventive Medicine and Rehabilitation Center, Howard C. May, PT – not dated.
13. Physical therapy progress notes, Health South, San Antonio, Texas 2-12-04 though 7-29-04.
14. PI solutions, investigative report – 09-28-04.
15. Letters of medical necessity, Pain and Mental Health Evaluation and PO letter, Neuva Vida Behavioral Health Associates – 02-08-05 through 03-31-05.
16. Prescription for neuromuscular stimulator, Tapron Medical Supplies Inc. – 08-02-04.
17. Member prescription profile report – date unknown.

REQUESTED SERVICE

The requested service is a chronic pain management program 5x/week for four to eight weeks.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

There have been no objective findings to support ___'s complaints of pain. Her clinical examinations, imaging studies and electrodiagnostic tests have shown no objective neurological abnormalities. She alleges tenderness in her left SI region, but this is a subjective phenomenon, which requires patient participation. She has not responded to appropriate interventions such as trigger point injections, SI joint injections and epidural steroid injections.

There is discordance between her alleged symptoms of pain and the observed activities noted on the video tape surveillance of September 17, 2004 indicating that she remains quite active physically. She is able to climb in and climb out of a boat, she is able to bend and pick up rocks weighing 10 pounds from in front of the trailer wheels. She is able to carry objects and place them in the boat. She is able to sit down in the grass and get up without difficulty. She is able to drive the boat and assist her husband in launching the boat from its trailer. None of these findings would indicate a capacity so severe that ___ would be incapable of working in her normal capacity. None of these findings would indicate the presence of a pain condition so impairing that referral for a comprehensive pain management program would be medically necessary.

REFERENCES

1. Pawl, R. "The Multidisciplinary Pain Treatment Program", Neurosurgical Pain Management K. Follett, ed. Elsevier (Philadelphia, PA) 2004
2. Mooney, V. "Outpatient Rehabilitation of the Spine Patient", Principles and Practice of Spine Surgery A. Vaccaro, ed. Mosby (Philadelphia, PA) 2003

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

Wendy Perelli, CEO

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) 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 (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 Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

Wendy Perelli, CEO

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 17th day of June 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli