

August 18, 2005

TEXAS WORKERS COMP. COMISSION
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M2-05-2164-01
CLIENT TRACKING NUMBER: M2-05-2164-01

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, 8/8/05
Notice of receipt of Request for Medical Dispute Resolution, 8/8/05
Medical Dispute Resolution Request/Response
Table of Disputed Services
List of Providers
Letter to ___ from Texas Association of School Boards, Inc., 6/14/05, 7/8/05
Preauthorization Decision and Rationale, Texas Association of School Boards, Inc., 6/14/05, 7/8/05
History and Physical, Joe Ellis Wheeler, MD, 6/30/05
History and Physical, Charles Marable, MD, 6/5/05

(continued)

Records Received from Respondent, TASB Risk Management Fund:

Prospective Review (M2) information request, 8/8/05
Prospective Review (M2) Response, 8/8/05
Preauthorization Decision and Rationale, Texas Association of School Boards, Inc., 6/14/05, 7/8/05
Notice of receipt of Request for Medical Dispute Resolution, 7/25/05
Notice of Duplicate request, 7/27/05
Medical Dispute Resolution Request/Response
Table of Disputed Services
List of Providers
Instructions for Completing the TWCC-60
Letter from ____, 7/20/05
Peer Review, Robert Holladay, 2/23/05
Independent Medical Examination form
Independent Medical Examination, Charles Xeller, MD, 4/26/05
Radiology report, 10/4/04
Radiology report, 3/3/05
Radiology report, 2/19/05
Radiology report, 4/19/05
EMG studies, 3/22/05
Texas Workers Compensation Work Status Reports, 10/1/04, 10/18/04, 11/15/04, 12/9/04, 12/30/04, 1/18/05, 1/28/05, 1/30/05, 2/7/05, 2/22/05, 2/28/05, 3/2/05, 3/9/05, 3/16/05, 3/30/05, 4/13/05, 4/22/05, 4/27/05, 5/31/05, 6/30/05,
New patient evaluation, Byron Strain, MD, 10/1/04
Follow up evaluations, Byron Strain, MD, 10/19/04, 11/17/04
Physical Therapy Evaluation, 10/4/04
Physical Therapy progress notes, 10/4/04 - 11/11/04
Office notes, The Neighborhood Doctor, 12/9/04, 12/30/04, 1/18/05, 1/28/05, 2/7/05, 2/22/05, 3/2/05, 3/16/05, 3/30/05, 4/13/05, 4/27/05, 5/31/05, 6/30/05, 7/11/05
Solutions In Therapy, Daily Therapy Charges, 1/3/05 - 2/11/05
Office notes, Christopher Wong, MD, 2/28/05, 3/9/05, 4/22/05
Office notes, Christine Huynh, MD, 5/11/05
Evaluation and H&P, Charles Marable, MD, 6/5/05
Evaluation, Charles Marable, MD, 7/11/05
Office notes, Linden Dillin, MD, 7/19/05
History and Physical, Joe Wheeler, MD, 6/30/05
Letter from Joe Wheeler, MD, 7/27/05
Prescription, Charles Marable, MD, 6/6/05
Physician to Physician Referral, 6/9/05
H&P, Charles Marable, MD, 7/11/05, 8/2/05

Records Received from Dr. Wheeler:

Letter from Joe Wheeler, MD, 7/27/05
History and Physical, Joe Wheeler, MD, 6/30/05

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Consultation, Linden Dillin, MD, 6/22/05

H&P, Charles Marable, MD, 6/5/05

Radiology report, 3/3/05

Radiology report, 2/19/05

New patient information and Questionnaire, Drs. Smith and Wheeler, 6/30/05

Summary of Treatment/Case History:

On ___ this 39 year-old had a slip and fall accident on a wet floor. She hit the floor, landing on her right knee and leg, twisting her right ankle. Another history is she hit the floor in the sitting position with her right leg underneath her. Another history is she landed partially weight bearing on her right arm. Since then she has had headache, neck pain, right shoulder pain and low back pain. The record is not clear, but she may have returned to work after several weeks or months. But she has not worked since February 2005.

She has undergone physical therapy, exercise therapy, massage, electrical muscle stimulation, and taken pain medication. Despite all modalities of therapy, she remains in pain in the above areas if without medication. But even medication does not relieve her pain.

Examination has shown muscle spasm in the neck and low back. Various areas of tenderness were noted in the neck, shoulder, lumbar spine, sacroiliac joints. Decreased range of motion was noted in the cervical and lumbar spine. The most recent neurological exam showed "motor exam is decreased in her arms and legs at about 4/5, sensory intact, reflexes 2+."

Radiographs of the foot, ankle, thoracic spine are normal. MRI of right shoulder has been variously reported as normal or possible minimal rotator cuff tear. Cervical spine films show normal osseous structure with reversal of the normal curve suggestive of muscle spasm. MRI of cervical spine shows a 3mm bulge at C4-5, with 1-2mm bulge at L3-4 and C5-6. EMG of upper extremities is negative.

The diagnosis varies, listed as right rotator cuff tear, cervical strain, thoracic strain, lumbar strain, "lumbar disc," and "cervical disc at C4-5."

Questions for Review:

1. Pre-authorization is requested for cervical lumbar myelogram with post CT scan.

Explanation of Findings:

The diagnosis of a herniated disc should be based on the history, physical examination and to confirm the clinical impression of a herniated nucleus pulposus laboratory studies such as EMG, CT, MRI, myelogram. These are not objective tests, but as all things subject to interpretation and thus, no more reliable than a history and physical. The diagnosis must be based on the totality of the case study. In a HNP there is a classic history, physical and laboratory study – the pattern does not always fit this picture, but in the majority of cases it does. The classic history is repeated episodes of neck and/or back pain due to fissuring of the annulus fibrosis related to minor trauma and degeneration over time as there is dehydration and aging of the spine tissues.

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It is most unusual for a young person as in this case with one episode of trauma to have an acutely ruptured disc. The compressive force to cause this is tremendous and would not be likely in a slip-and-fall accident. If the disc ruptures acutely, it causes back and extremity pain that is radicular. Such is not the case here. That is, while there is back pain, there is no radicular pain. Neck and back pain, limitation of ROM, back and neck spasm, tenderness of muscles are very non-specific findings, and only indicate there is some non-specific problem in these areas. This patient has such non-specific complaints that have been documented and treated and may have improved and are helped by medication. There are specific neurological findings in a HNP consisting of muscle weakness in a given muscle group, reflex loss or decrease localized to the nerve root involved and sensory changes in a dermatomal pattern. This patient has no such documented findings.

EMG, while not 100% accurate, can often locate the nerve root involved – the EMG here is normal. Plain films of the neck and spine will often show degenerative changes – no such are described here. MRI again is not 100%, but often shows changes in keeping with a HNP and is diagnostic as in CT. As myelogram CT is done only to confirm the lesion as to location, if all other studies have not established a diagnosis in most cases it is not required. In this case, the history, physical and laboratory studies do not support a diagnosis of HNP, so see no need to proceed further. There is support for a diagnosis of cervical and lumbar and shoulder trauma with a chronic pain state.

A request for cervical and lumbar myelogram with post CT scan has been made. For reasons mentioned above, there is no necessity this. Only non-specific neck and back pain are noted with negative neurological findings, negative EMG and only bulges in MRI of cervical spine. No further invasive procedures are needed. Incidentally, although CT myelogram of lumbar spine requested, there are no records of plain films or MRI and non-enhanced CT of lumbar spine. Most would do these before going to a myelogram.

This individual has a condition called "Chronic Pain State." This is usually best treated by a specialist in chronic pain management, who can utilize various methods of therapy rather than surgery.

This individual is 5'4" tall and weighs 177 pounds. This is over the usually accepted weight standard for most authorities and excess weight may play some part in her chronic low back pain. Also much of chronic low back pain is related to posture and as muscle spasm and decreased range of motion in the back is described, her posture is not normal.

After almost a year of pain from a fall, the neurosurgeon in this case has referred this patient for a final diagnosis. The chance of finding a surgical lesion at one level in the neck or lumbar area causing such widespread symptoms is remote.

Conclusion/Decision to Not Certify:

1. Pre-authorization is requested for cervical lumbar myelogram with post CT scan.

The proposed cervical lumbar myelogram with post CT scan is not medically necessary in this case.

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References Used in Support of Decision:

P. Ray, M.D. – Practical Management of Pain. W. B. Saunders, 2002.

Chapman's Orthopedic Surgery. Lippincott Williams and Wilkins (2001)

Section VIII – The Spine Disc Injury and Degeneration

Chapter 143 – Cervical Disc Disorder

Chapter 144 – Lumbar Disc Disorder

The specialist providing this review is board certified in Neurosurgery. The reviewer has served as the chief Neurosurgeon at several VA Hospitals throughout the country. The reviewer is a member of the American Medical Association, the American College of Surgeons, the American Paraplegia Society, Congress of Neurological Surgeons and the American Association of Neurosurgeons. The Reviewer has served as an association professor, assistant professor and clinical instructor at the university level. The reviewer also has publishing, presentation and research experience within their specialty. The reviewer has been in active practice for over 20 years.

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 / Appeals Clerk

P. O. Box 17787

Austin, TX 78744

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

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

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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 MRloA 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 MRloA 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 MRloA 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: Requestor
Respondent