

IRO America Inc.
An Independent Review Organization
7626 Parkview Circle
Austin, TX 78731
Phone : 512-346-5040
Fax: 512-692-2924

facsimile transmittal

To: Fax: 512-804-4868
From: IRO America Date: 3/27/2008
Re: Final Decision Letter Pages: 7
Cc:

Urgent For review Please Please reply Please recycle

IRO America Inc.

An Independent Review Organization

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

March 16, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____

TDI-DWC #: _____

MDR Tracking #:

M2-06-0719-01

IRO #:

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed MD, board certified and specialized in Orthopedic Surgery. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

- EMG/NCV, 02/24/04, 01/19/05, 04/06/05
- Lumbar MRI without gad, 03/19/04
- Office note, Dr. Maffet, 04/20/04, 04/27/04, 06/22/04, 07/06/04, 08/03/04, 09/14/04, 10/26/04, 11/30/04, 01/18/05, 03/01/05, 03/29/05, 04/26/05, 06/07/05, 08/09/05, 09/20/05, 11/01/05 and 01/10/06
- Cervical spine, MRI, 05/10/04
- Ct of head with and without contrast, 12/17/04
- Office note, Dr. Hicks, 01/06/05, 11/15/05

- Office notes, Dr. Athari, 01/19/05, 02/02/05, 02/09/05, 02/16/05, 03/02/05, 03/16/05, 03/30/05, 04/06/05, 04/27/05, 05/10/05, 05/24/05, 06/02/05 and 06/14/05
- Operative report, 03/07/05, 05/23/05
- Lumbar and cervical spine MRI, 06/23/05
- Office note, Dr. Francis, 07/30/05, 08/20/05, 08/30/05 and 10/18/05
- X-rays thoracic spine, 08/01/05
- Thoracic spine MRI, 08/01/05
- Thoracic spine MRI without contrast, 08/16/05
- Office note, Dr. Riser, 08/18/05
- Office note, Dr. Gertzbein, 08/24/05
- Office note, Dr. Williamson, 09/19/05
- Progress notes, Dr. Gutierrez, 09/19/05, 09/29/05, 09/30/05, 10/3/05, 10/5/05, 10/7/05, 10/10/05, 10/12/05, 10/13/05, 10/17/05, 10/19/05, 10/21/05, 10/25/05, 10/27/05, 10/31/05, 11/2/05, 11/4/05, 11/7/05, 11/9/05, 11/11/05, 11/14/05, 11/16/05
- Addendum, Dr. Williamson, 10/17/05
- Office note Dr. Hanson, 11/03/05 and 11/22/05
- Cervical myelogram and CT, 11/11/05
- Request for authorization for repeat EMG/NCV, 11/28/05
- Peer reviews, 12/02/05 and 12/07/05
- Notes from Liberty Mutual, 01/11/06 and 01/31/06

CLINICAL HISTORY

The Patient is a 45 year-old male, who developed head, neck, left knee and left elbow pain after a _____ injury. He sustained a fractured left fibula below the knee and had surgery on the left knee on 11/11/03, apparently consisting of an ACL reconstruction. He was also noted to have had a previous injury to his neck and shoulder in 2002, with was exacerbated with the current injury. He later developed weakness, numbness and tingling in both arms and hands and electrical shock feeling in the low back radiating to the left leg. His history was also significant for diabetes, hypertension and hypercholesterolemia.

EMG/NCV studies of 02/24/04 demonstrated evidence of left L5-S1 radiculopathy and it was felt that the left knee pain was possibly coming from the back and the knee.

An MRI of the lumbar spine on 03/19/04 showed facet joint degenerative change of L3-4, L4-5 and L5-S1. An MRI of the cervical spine on 05/10/04 showed 5/10/04 straightening of the usual cervical lordosis; C3-4 showed right uncinat hypertrophy with spondylotic foraminal encroachment; C5-6: broad based posterior bulge/spondylosis with bilateral spondylotic foraminal encroachment; C6-7: broad based posterior bulge/spondylosis with superimposed right posterolateral focal protrusion/herniation that could affect the exiting C7 nerve root.

The Patient was found by Dr. Maffet to have a left ACL/MCL deficient knee and on 06/25/04 underwent a revision ACL reconstruction. He did well postoperatively with improved strength and motion by 11/30/04.

A CT of the head on 12/17/04 showed a small focal density in the upper portion of the scalp on the left near the vertex, possibly a calcification in the hematoma of the scalp.

Some time prior to 01/06/05 The Patient had a functional capacity evaluation which noted that he was performing at a light medium work class and needed to be at a very heavy capacity. Dr. Athari evaluated The Patient on 01/19/05 with complaints of intermittent neck and

back pain as well as intermittent headaches. The impressions were cervical radiculopathy, lumbar herniated disc with radiculopathy, post concussion headache syndrome. EMG/NCV and EEG studies, continuation of current medications, Ultracet, Elavil and Neurontin were recommended. EEG studies of 01/19/05 were normal. EMG/NCV studies of the upper extremities on 01/19/05 were suggestive of bilateral C5-6 radiculopathy, more prominent on the right.

On 03/07/05 The Patient underwent examination of the left knee under anesthesia and open medial collateral ligament reconstruction with proximal and distal reefing. EMG/NCV studies of the upper extremities on 04/06/05 was suggestive of mild lumbar nerve root irritation involving the L5-S1 level on the left. The Patient continued treating for radiating neck and back pain through 06/14/05 with Robaxin, B12 and Depo Medrol injections. He also continued treating for his postoperative knee and was continuing to work on strengthening of his quadriceps.

An MRI of the lumbar spine of 06/23/05 showed no specific positive findings. An MRI of the cervical spine that day showed diffuse disc herniations at C5-6 and C6-7.

Dr. Francis evaluated The Patient on 07/30/05 for predominantly neck pain and pain between the shoulder blades with numbness and tingling of the hands, particularly the index, long and ring fingers on the right. He was diagnosed with disc herniations at C5-6 and C6-7 with predominantly neck pain and some arm symptoms. An anterior cervical decompression and fusion of C5-6 & C6-7 was recommended. X-rays of the thoracic spine on 08/01/05 were normal. An MRI of the thoracic spine on 08/16/05 showed no thoracic neural foraminal or spinal stenosis. The thoracic cord was of uniform and normal signal. There was mild spondylosis, with disc desiccation at T7-11 and minimal posterior disc bulges at T7-9 without paravertebral soft tissue abnormality. Sagittal sequences showed anatomic alignment of the thoracic spine, without focal marrow signal abnormality. There was desiccation of T7-11 discs, with minimal posterior disc bulges at T7-9 without significant spinal stenosis, focal cord signal abnormality or neural foraminal stenosis, paravertebral or other soft tissue abnormality. He had spondylosis of the cervical spine with loss of disc height and posterior disc bulges at C5-7, axial sequences showed no significant neural foraminal or spinal stenosis and there was no paravertebral soft tissue abnormality. On 08/20/05 Dr. Francis again saw The Patient. X-rays showed well preserved disc space height, very mild retrolisthesis of L5 on S1. He diagnosed The Patient with chronic back strain with facet mediated pain and recommended weight loss and facet injections and possible radiofrequency ablation rather than surgical intervention. On 08/24/05 Dr. Gertzbein felt that The Patient was not a good surgical candidate due to his size and a short neck and recommended injections.

Dr. Williamson evaluated The Patient on 09/19/05 for radiating neck and shoulder pain, upper mid thoracic pain and radiating low back pain. The examination demonstrated some weakness in external rotation of the right shoulder, some tenderness over the upper thoracic region and some lower lumbar, knee and ankle reflexes of 1. X-rays of the cervical spine showed cervical spondylosis at C5-6 and C6-7. C6-7 showed posterior central protrusion. There was minimal degenerative change at 3-4. Axial reconstructive cuts of cervical region at 2-3 appeared to be intact as did 3-4. 4-5 appeared intact; 5-6 showed mild right and left neural foraminal narrowing; 6-7 right paracentral protrusion and 7-1 intact. X-rays of the thoracic spine that day showed intact pedicles, mild degenerative changes and multiple levels of degenerative change. Swimmers view of cervical spine 5-6 & 6-7 appeared intact. X-rays of the lumbar spine showed intact SI joints, hips and pedicles. There was retrolisthesis of 5 on 1, previous changes in the coccyx region. The impressions were: cervical spondylosis C5-6 and C6-7 with intermittent cervical radicular pattern, history of right shoulder symptoms with rotator cuff injury, thoracic degenerative disease, mild lumbar degenerative disease with intermittent bilateral L5 radicular

pattern, and history of left knee surgery with subsequent infection and 2 previous surgeries. Evaluation for the shoulder, physical therapy, exercise, weight loss and regular aerobic exercise for the lumbar spine, therapy for neck stabilization and stretching, walking, bike, and avoidance of re-injury to the neck and heavy lifting were recommended. As of 10/17/07 Dr. Williamson said The Patient was getting close to statutory MMI. On 10/17/05 x-rays showed intact hips and SI joints and pedicles, degenerative changes and mildly facets at 5-1 and 4-5 within the lower lumbar region. Flexion-extension views showed no gross instabilities. There was a Schmorl's node at 2-3 interval within the lumbar region including within the L3 vertebral body. The Patient continued treating with Dr. Gutierrez, chiropractor through 11/16/05. On 11/01/05 Dr. Maffet stated that The Patient was doing extremely well with his knee, but still a little bit of patellofemoral pain. A functional capacity evaluation had not been done as previously recommended, and was again requested.

A cervical myelogram of 11/11/05 showed C6-7 right paracentral disc herniation abutting and likely mass effect on the right anterior labral spinal cord. Clinical correlation for right C7 radiculopathy was recommended.

Dr. Hanson evaluated The Patient on 11/22/05 with complaints of neck pain and less right arm pain, usually related to continuous work with keypad of the computer. He reviewed the CT myelogram and requested EMG studies. These studies were denied by two previous reviews on 12/02/05 and 12/07/05. This is under appeal.

DISPUTED SERVICE(S)

Under dispute is the prospective, and/or concurrent medical necessity of bilateral lower extremity EMG and bilateral upper extremity NCV.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

It appears from this medical record that The Patient had a significant injury on _____ and injured multiple different areas of his body. Since that time he had a 02/24/04 EMG of the legs that showed a left L5-S1 radiculopathy, a 01/19/05 EMG of the arms that showed a bilateral C5-6 radiculopathy more prominent on the right and a 04/06/05 EMG of the lower extremities suggesting nerve root irritation L5-S1 on the left. The Patient had undergone multiple diagnostic tests documenting cervical and lumbar disc abnormalities and has currently seen Dr. Hanson who has requested EMGs of the upper and lower extremities. The Reviewer has reviewed this medical record and although The Patient continues to complaint of pain and symptoms, he does not appear to have a progressive neurologic deficit and it is not clear to why the EMGs have been re-ordered since they were previously done in the past, correlated with The Patient's subjective complaints, and there is no documentation in the medical record as to what the requesting physician is looking for with these tests. It is not clear to The Reviewer how repeating these tests and receiving either the same or different information is going to change the type of treatment that will be required out into the future. Clearly the onset of patient complaints and abnormalities on the EMG testing done previously would correlate and The Reviewer is therefore not sure what information would be gathered by these new tests that would change The Patient's need for treatment or type of treatment either now or out into the future.

Screening Criteria

1. Specific:

- AAOS, Orthopedic Knowledge Update, Spine, 2, Chapter 10, pages 85-86

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

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

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer

Cc: _____

Dr. Darrel Hanson
Fax: 713-986-5751

Liberty Mutual
Attn: Rebecca Shultz
Fax: 574-258-5349

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or The Patient's representative) and the DWC via facsimile, U.S. Postal Service or both on this 16th day of March, 2006.

Name and Signature of IRO America Representative:

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer