

IRO America Inc.

An Independent Review Organization

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

June 1, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____

TDI-DWC #: _____

MDR Tracking #: _____

M2-06-1126-01

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:

- Lumbar spine MRI, 03/27/03
- Lumbar spine MRI without contrast, 10/05/05
- Office note, Dr. Youngblood, 01/25/05, 05/11/05 and 01/31/06
- Lumbar discography, 03/04/05
- Texas Mutual Insurance Company approval, 03/16/05
- RME and office note, Dr. Robert, 07/28/05
- Independent Medical Evaluation, Dr. Xeller, 12/22/05
- Texas Mutual Insurance Company denial, 02/07/06
- Carriers Statement for Texas Mutual Insurance Company, LaTrece Giles, RN, Dispute Agent, 05/05/06

CLINICAL HISTORY

This is a 41 year old _____ groundskeeper with a history of chronic low back pain. A 03/27/03 lumbar MRI showed multiple level disc disease at L3-4, L4-5 and L5-S1. On _____, he lifted a power washer with a co-worker and experienced worsening of his low back pain complaints. A repeat lumbar MRI on 01/05/05 showed disc protrusion/extrusion at L3-4, L4-5 and L5-S1 impinging upon multiple nerve roots, bulging into the neural foramina at L3-4, and L4-5 and narrowing of the neural foramina at L4-5 due to facet arthropathy. On 01/25/05 evaluation by Dr. Youngblood, The Patient reported low back pain greater than left lower extremity pain. The Patient also reported the pain radiated down the anterior aspect of the left leg into his foot and intermittent paresthesias of the left lower extremity. The duration of the low back pain was three to four years. The Patient had treated with physical therapy for his past complaints without lasting benefit. He noted that his back pain limited his lifestyle, his activities of daily living and his ability to work. He was taking Skelaxin for his pain. Exam findings were mildly antalgic gait, able to toe walk but unable to heel walk on right, straight leg raise at 70 degrees produced low back pain, weakness of the right tibialis anticus, absent right knee jerk, hypalgesia along the inner left leg and foot, and left greater than right paravertebral muscle tenderness. Dr. Youngblood reviewed the 01/05/05 MRI. Dr. Youngblood's impression was lumbar spondylosis with facet arthropathy, lumbar spinal stenosis, degenerative disc disease and disc protrusion or extrusion L3 to S1. Dr. Youngblood felt The Patient had objective neurologic deficits with weakness in the tibialis anticus and had failed multiple epidural steroid injections and physical therapy. Dr. Youngblood's recommendation was decompressive laminectomy, foraminotomy, posterolateral fusion and pedicle screw instrumentation from L3 to sacrum with interbody fusion with cages as necessary. A 03/04/05 lumbar discography was normal at L2-3 and was abnormal at L3-4, L4-5 and L5-S1 for concordant pain at all three levels. The Patient was seen again by Dr. Youngblood with no improvement in his low back pain, left lower extremity pain and right leg paresthesias. The Patient required Talwin around the clock and was not working. Exam findings now showed mild weakness of left tibialis anticus and moderate to moderately severe weakness of right tibialis anticus. Dr. Youngblood felt that The Patient's neurological deficit had increased since the last examination and now involved the dorsiflexors bilaterally. Dr. Youngblood opined that the single greatest contributor at the very worst level on his imaging was a very large disc extrusion which markedly narrowed the spinal canal and impinged upon both the L5 nerve roots resulting in the bilateral dorsiflexor weakness. Dr. Youngblood remarked that The Patient had 75 to 80 percent back pain.

On 07/28/05, Dr. Roberts performed a required medical exam. The Patient reported worsening of his low back and bilateral leg pain. The pain radiated from his low back into this buttock and down the left anterior thigh to knee. The Patient reported the pain on the right side radiated all the way down the anterior right leg to foot with tingling into the top of the right foot.

The worst pain was in his low back and thigh associated with tingling on the left side of the thigh. Physical exam findings revealed normal gait, the ability to toe walk with either leg but cannot heel walk with the right foot, tenderness of the lumbar spine, both flexion and extension of the lumbar spine was painful. The left knee reflex was absent. The right lower extremity reflexes were intact and symmetrical. Sensation was diminished to the medial side of the right shin and to top of the foot in an L4 and L5 distribution. Motor strength revealed weakness in right extensor hallucis longus and right ankle dorsiflexors were 4/5. The motor strength through out the remainder of the leg and all of the left leg was normal. Straight leg was pain free. According to Dr. Roberts, the MRI of the lumbar spine showed a large central disc herniation at L3-4 with resultant central stenosis, disc narrowing at L4-5 with a large midline right sided disc herniation at L4-5 level. The L5-S1 showed just mild disc desiccation with a small central disc protrusion without neurologic impingement. Dr. Roberts' impression was disc herniation consistent with a lifting injury. Recommendations were epidural steroid injections; however, Dr. Roberts agreed with Dr. Youngblood's recommendation of surgery.

On 12/22/05, Dr. Charles F. Xeller, performed an independent medical examination. At that time, The Patient reported ongoing back and bilateral leg pain. Exam finding revealed limitations in lumbar motion in all planes. The Patient had a negative left straight leg raise with minimal consideration of pulling, normal reflexes, negative Patrick and Trendelenburg signs, no instability, no spasm, no alteration in sensation and no atrophy. The Patient got on and off the examination table without difficulty and had a normal gait. Dr. Xellar's impression was that the exam was benign and that The Patient had three bulges and poor insight into his medical condition. Dr. Xeller further noted that there was no overt radiculopathy, no instability but had a chronic history of low back pain with a concordant discogram. On imaging, The Patient may have worsening of his condition from L3 to L5. Dr. Xeller placed The Patient at maximum medical improvement and gave The Patient a 10 percent impairment rating for his degenerative changes and spinal stenosis. Dr. Xeller felt The Patient was capable of working light duty with restrictions of no lifting greater than 20 pounds.

Dr. Youngblood saw The Patient again on 0/31/06 and noted no improvement over the last several months. The Patient reported persistent low back pain with paresthesias down the left lower extremity unrelieved with Talwin and Skelaxin. Dr. Youngblood's impression was radiculopathy with neurologic deficits as well as refractory pain. Again surgery was recommended. On 02/7/06, The Texas Mutual Insurance Company denied the requested procedure. A Carrier Statement from Texas Mutual Insurance Company on 05/05/06 concluded that the requested surgery was reviewed and denied as The Patient was neurologically intact with a negative straight leg raise and no instability. The statement further documented that on 02/28/06, a physician advisor had agreed the L5 nerve root required decompression but a fusion was not recommended.

DISPUTED SERVICE(S)

Under dispute is the prospective, and/or concurrent medical necessity of L3-S1 decompression lumbar laminectomy, foraminotomy, posterolateral fusion with iliac crest bone graft, steffe pedicle screws, L3-S1 posterior lumbar interbody fusion, wibrantigan cages at L3-4 and L5-S1 and autograft, Two-day length of stay.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

The Reviewer recommends the proposed L3-S1 decompressive laminectomy, foraminotomy and fusion with an iliac crest bone graft and pedicle screws along with the Wibrantigan cages and autograft as being medically necessary along with the two-day length of stay for This Patient. Dr. Youngblood and Dr. Roberts both find significant spinal stenosis with neurologic imbalance and significant neurologic compromise that corresponds to the MRI findings with a large central disc herniation at L3-4 with resultant central canal stenosis and also disc narrowing as result with stenosis at L4-5. The Patient has a positive discogram at L5-S1. Dr. Xeller, an Independent Medical Evaluator, in December 2005 did not find the neurologic changes but the review of these records indicates that two physicians found neurologic changes-one did not. The preponderance of evidence would indicate that This Patient, at least from the standpoint of the physicians' examination, has central canal stenosis with disc herniations causing neurologic compromise. The Patient has failed conservative treatment and the proposed decompression would be reasonable and appropriate under those circumstances.

Screening Criteria

1. Specific:

- ACOEM chapter 12, pg 305 to 307
- ODG Treatment in Workers' Comp, 4th edition, 2006, pg 806 and 814

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.

incerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolution Officer

Cc: _____

Texas Mutual Ins.
Fax: 512-224-7094

Dr. Lloyd Youngblood
Fax: 210-949-0171

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 1st day of June, 2006..

Name and Signature of IRO America Representative:

incerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolution Officer