November 16, 2005

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

Patient: ___
DWC #: ___
MDR Tracking #: M2-06-0225-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC 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 DWC 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. ___ suffered an on the job work injury to her back on ___. There were no specific details submitted from the time of her injury.

Records from Dr. Pedro Nosnik, a neurologist, indicated an office visit on September 26, 2003. He saw her for lumbar radiculopathy. She had undergone a percutaneous diskectomy 7 weeks prior to that visit. She was having pain in her back and right gluteal region, which got worse after surgery. The pain was also radiating into the anterior groin area and the anterior and posterior aspect of the thigh going down into the leg and foot with numbness of the sole of the foot. Dr. Nosnik's examination showed discomfort with straight leg raising on the right side at 70 degrees causing pain in the back, which did not radiate down the right lower extremity. The ankle reflexes were trace bilaterally. She had decreased sensation on the medial plantar aspect of the right foot. There were no long tract signs. She could tiptoe and heel walk with some pain

and discomfort in the back and gluteal region on the right side. EMG and nerve conduction studies showed a chronic right L5 radiculopathy with no active changes. Dr. Nosnik's impression was status-post lumbar percutaneous diskectomy with right lower extremity pain with chronic right L5 radiculopathy.

The records then skip to August of 2004, when she presented to Dr. Daniel Hopson, a neurologist. Dr. Hopson's impression was distal lower extremity dysesthesias and sensory loss status-post back injury, lumbar pain chronic, and lumbar radicular pain on the left, status-post back injury, history of lumbar disk disease at multiple levels, abnormal neurologic examination with findings of distal symmetric sensory loss and diminished ankle reflexes, abnormal EMG and NCS of the lower extremities with delay in H-reflex and absent sural sensory potential with intact motor conduction, suggestive of S1 radiculopathy, bilateral and mild sensory neuropathy. He recommended follow-up with Dr. Marks regarding her back pain and follow-up with her primary care physician regarding workup for her neuropathy. No further notes were submitted from Dr. Hobson.

Notes from Dr. Richard Marks dated August 26, 2004 to September 06, 2005 indicate worsening pain in the right ischial tuberosity with pain in the left leg worse than in a prior evaluation. A CT of the pelvis done on May 26, 2004 showed no evidence of infection. Blood work was normal. Review of an MRI done on August 04, 2004, which was a seated flexion and extension MRI showed diffuse reversal of the lower lumbar lordosis. There were multilevel lumbar spondylitic changes present with significant disk dehydration at the lower 4 lumbar levels, significant loss of height at L5-S1 and to a lesser extent at L4-5 with no compression fracture or spondylolisthesis. Dr. Marks recommended a second opinion consultation with Dr. John Peloza, also a spine specialist. Dr. Marks prescribed Ultracet.

She returned to see Dr. Marks on September 06, 2005 nearly a year later. She was reporting back pain, which was tolerable. She described this as though her legs were being wrung out like a towel. She had recurrent numbness right more than left in the anterior and lateral calf to the ankle level, but also in the toes, and the feet. An MRI done on August 04, 2004 showed multilevel spondylotic changes with no evidence of definitive or significant neurocompression. They had discussed the possibility of myelogram. Dr. Marks recommended a repeat MRI, CBC, and sed rate, and neurological evaluation of her lower extremities.

Test results submitted included an enhanced MRI of lumbar spine done on October 31, 2003. This showed enhancement of the L5 and S1 vertebral bodies as well as the epidural space and the anterior paravertebral bodies as well as the epidural space and the anterior paravertebral soft tissues consistent with diskitis and osteomyelitis of L5-S1 and the L5-S1 interspace. A bone scan taken on February 09, 2004 showed areas of increased uptake along the L5 vertebral body. An MRI of the lumbar spine with and without contrast including flexion and extension views showed at L3-4, a diffuse generalized annular disk bulging with flattening of the posterior annular contour and subtle T2 hyperintensity within the posterior annulus at the midline compatible with annular fissure. At L4-5 there was mild generalized annular disk bulging noted

with bilateral facet arthropathy, and hypertrophy, but no significant central or foraminal stenosis. The L5-S1 and L2-3 levels were unremarkable.

EMG and nerve conduction studies done on August 20, 2004 by Dr. Hobson showed an absent left sural sensory response. The right side was note tested. Peroneal F-wave latencies were normal. H-reflexes were slightly prolonged. EMG and nerve conduction studies showed mildly reduced recruitment in the right extensor digitorum-brevis muscles bilaterally, but were otherwise unremarkable.

RECORDS REVIEWED

1. Neurological consultation and EMG, Padro Nosnick, MD, September 26, 2003.
2. Neurology evaluation and EMG study, Daniel Hopson, MD, August 20, 2004.
3. Office progress notes, Richard Marks, MD, August 26, 2004 and September 9=06, 2005.
4. Enhanced MRI of the lumbar spine, October 31, 2003.
5. Bone scan, February 09, 2004.
6. MRI of the lumbar spine with and without contrast including flexion and extension views, August 04, 2004.
7. Pre-authorization and determinations, CorVel Corporation, September 23, 2005 and September 30, 2005.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a repeat lumbar MRI and bilateral lower extremity EMG/NCV.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states that Ms. ___ likely has tandem causes for her lower extremity complaints namely that of a peripheral neuropathy and lumbar degenerative spine disease. These diagnoses have already been established by the previous investigations done in 2004. Repeating them would not add to her management. What is necessary is to determine if possible the cause of her peripheral neuropathy. Even if her lumbar MRI showed worsening spondylosis, it is unlikely given her history of osteomyelitis and diskitis following prior surgery that she would be an appropriate candidate for further surgical intervention.

References:

American College of Occupational and Environmental Medicine. *Occupational Medicine Practice Guidelines.* Beverly Farm, Massachusetts: OEM Press. pp287-329.

American Academy of Neuromuscular and Electrodiagnostic Medicine. Guidelines for Electrodiagnostic Consultation. February, 2002.

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 the reviewing provider has no known conflicts of interest between that provider 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 carrier health care providers who reviewed the case for decision before referral to the IRO.

Sincerely,

Wendy Perelli, CEO

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.

Sincerely,

Wendy Perelli, CEO

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 claimant's representative) and the via facsimile, U.S. Postal Service or both on this 16th day of November 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli