

MCMC

IRO Medical Dispute Resolution M2 Prospective Medical Necessity IRO Decision Notification Letter

Date:	02/14/2006
Injured Employee:	
Address:	
MDR #:	M2-06-0514-01
DWC #:	
MCMC Certification #:	IRO 5294

REQUESTED SERVICES:

Please review the item(s) in dispute: Pre-authorization request-anterior cervical discectomy with fusion and plating C3-4.

DECISION: **Upheld**

IRO MCMC llc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M2 Prospective Medical Dispute Resolution on 02/14/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The requested anterior cervical discectomy and fusion (ACDF) at C3/4 is not medically necessary.

CLINICAL HISTORY:

This male injured individual, 54-year-old, was allegedly injured on _____. He was first seen on 04/05/2005 complaining of constant low back and neck pain rated of 9/10 level with radiation to both legs and right arm. In addition he allegedly had "frequent pain in the midback and pins and needles in the right leg. The injured individual described his injury as a fall from a ladder about 12 to 13 feet high. The injured individual claimed that he could not remember the duration of time during which he was unconscious.

The MRI of 04/11/2005 revealed a previous laminectomy defect at L5, small right herniated nucleus propulsus (HNP) with mild canal stenosis at L2/3 and L4/5. There were moderate bilateral facet degenerative joint disease (DJD) at L2/3 and L4/5. The MRI of the cervical spine on 04/14/2005 revealed a mild disc bulge at C3/4, a moderate annular bulge at C5/6 and small osteophytes that narrowed the right C5/6 foramen.

Dr. Whitt [? rehab] evaluated the injured individual on 04/19/2005 for low back and neck pain and a sensation of his right leg "giving out". He has a history of coronary artery disease (CAD) and stent placement, hypertension (HTN) and hyperlipidemia. On examination the only finding

was tenderness over the low back and neck, and limited range of motion (ROM) of the neck with pain on rotation. The EMG/NCV studies on 04/21/2005 of bilateral upper and bilateral lower extremities were completely normal.

REFERENCE:

The Spine. Orthopedic Knowledge Update. Published by AAOS 2002.

RATIONALE:

Dr. LeGrand [neurosurgeon] evaluated the injured individual on 04/28/2005 for low back and neck pain. He had undergone a laminectomy at L5/S1 performed 30-years earlier. He was taking numerous medications for his medical problems and had been receiving physical therapy (PT) and chiropractic care. The injured individual was noted to be 5'7" tall weighing 210 pounds. He had what appears to be a stooped posture and some decrease in range of motion (ROM) of the neck in all directions. He had a full range of motion of both shoulders. He had decreased mobility of his low back and straight leg raise (SLR) test was apparently positive at 45 degrees bilaterally. He had no focal findings of nerve root compression or irritation. He was to continue with Ibuprofen and Lortab. Despite the absence of objective clinical and imaging findings of nerve root compression he was referred for epidural steroid injection (ESI) for the neck and low back.

On 5/10/2005 Dr. Whitt increased the dose of Hydrocodone. Once again the only clinical finding documented is tenderness in the lumbar paraspinal region and limited ROM. There are no details in the office note to confirm whether a detailed examination was performed. The injured individual apparently had a Functional Capacity Exam (FCE) completed on 06/15/2005 and was deemed to be capable of work at a light to medium capacity. A second FCE completed on 07/11/2005 reduced his level of function to a light physical demand level. The report suggests that the main problem was related to his complaints of severe low back pain (LBP) with lifting.

On 08/05/2005 because the injured individual complained of chronic neck and low back pain radiating to his extremities Dr. LaGrand ordered a myelogram/CT scan. The lumbar myelogram was reported to be unremarkable and the post myelogram/CT scan only revealed a broad based disc bulge at L4/5 and the post operative changes at L5/S1. The cervical myelogram revealed some narrowing of the thecal sac at C3/4. The post myelogram/CT scan revealed prominent posterior osteophytes and broad based disc bulges at C6/7. There was a focal herniated nucleus propulsus (HNP) at C5/6, which did not come in contact with the cord. There were prominent multilevel spondylitic changes.

Dr. LeGrand's interpretation of the myelogram/CT scan images was completely different from that provided by the radiologist. The neurosurgeon believed that there was "a fairly large and bilateral defect at C3/4 with some cord compression". Based on his interpretation, he recommended possible surgical treatment. Dr. Whitt seem to agree with the neurosurgeon's recommendation on the basis that the cervical surgery was "more appealing as its success rate is higher".

On 09/22/2005 Dr. Hagstrom gave the injured individual an ESI in the neck. On 10/13/2005 the injured individual claimed that the ESI had only given him pain relief for a few days. Once again surgical treatment was recommended. Dr. LaGrand wrote a letter dated 10/27/2005 to the chiropractor that has been treating him questioning the denial of surgery. The neurosurgeon felt that the radiologist had mentioned narrowing of the thecal sac at C3/4. This is accurate, however, there is no documentation of any sign of cord compression. In fact the post myelogram/CT scan does not even address the C3/4 level.

On 11/8/2005 the injured individual informed Dr. Whitt that the Ultram had allegedly caused some cardiac problems for which he went to the emergency room (ER). He also claimed to feel "more run down and in general, weaker". There was some issue about his reaction to Lipitor. Dr. Whitt questioned the possibility of whether the Lipitor had an "adverse effect on his muscle tissue". Dr. Whitt makes a point of stating that the "Ultram was destroyed along with the witness and there is a separate sheet documenting that".

On 12/06/2005 the injured individual reported that two of the stents had been replaced. Dr. Whitt reported the injured individual was to again begin taking Hydrocodone, Lipitor, Prevacid and Plavix. The treating chiropractor {Dr. Coolbaugh} placed him at maximum medical improvement (MMI) and gave him a 15% PPI rating.

The MRI study of 04/14/2005 revealed a diffuse annular bulge at C3/4. The lumbar myelogram was reported to be unremarkable and the post myelogram/CT scan only revealed a broad based disc bulge at L4/5 and the post operative changes at L5/S1. The cervical myelogram revealed some narrowing of the thecal sac at C3/4. The post myelogram/CT scan revealed prominent posterior osteophytes and broad based disc bulges at C6/7. There was a focal HNP at C5/6, which did not come in contact with the cord. There were prominent multilevel spondylitic changes. Based on the available information there is no documentation of objective clinical or imaging findings to substantiate the need for the requested procedure.

Individuals who have multilevel degenerative spondylosis in the cervical spine are not candidates for decompression and fusion unless there are well-defined objective clinical findings. These findings would include neurological changes and well localized clinical signs and symptoms. The imaging studies should also clearly demonstrate a lesion that is commensurate with the clinical signs and symptoms. The clinical notes documenting his complaints fails to identify a well-defined radiculopathy. There is inconsistency between the complaints, clinical and imaging findings. In fact, there are few objective clinical and imaging findings commensurate with the complaints. The imaging and clinical findings do not substantiate the need for the requested procedure. The injured individual has ongoing cardiac problems and recently had placement of two stents.

RECORDS REVIEWED:

- Notification of IRO Assignment dated 01/02/06
- MR-117 dated 01/02/06
- DWC-60

- DWC-69: Report of Medical Evaluation
- MCMC: IRO Medical Dispute Resolution Prospective dated 01/25/06
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 01/05/06
- Coolbaugh Chiropractic: Impairment Evaluation dated 01/03/06 from Robert Coolbaugh, D.C.
- Winston Whitt, M.D.: Multidisciplinary Pain Management Follow Up Notes dated 12/06/05, 11/08/05, 09/06/05
- Corvel: Pre-Authorization Determination dated 11/10/05
- Robert H. LeGrand, Jr., M.D.: Letters dated 10/27/05, 10/13/05, 08/30/05, 08/05/05, 04/28/05
- Corvel: Pre-Authorization Determination dated 10/20/05
- David Hagstrom, M.D.: Letter dated 10/10/05
- Covenant Surgicenter: Operative Report dated 09/22/05 from David Hagstrom, M.D.
- Shannon West Texas Memorial Hospital: Operative Report dated 08/19/05 from Robert LeGrand, M.D.
- Shannon West Texas Memorial Hospital: Myelogram of the cervical and lumbar spines dated 08/19/05, post myelogram CT scan of the lumbar spine dated 08/19/05
- Lubbock Accident and Injury Rehabilitation: Functional Capacity Evaluations dated 07/11/05, 06/15/05 from Kathryn Rowell, OTR
- Lubbock Accident and Injury Rehabilitation: Physical Performance Evaluation dated 05/11/05 from Kathryn Rowell, OTR
- Winston Whitt, M.D.: Follow Up Note dated 05/10/05
- Roger Wolcott, M.D.: Electrodiagnostic report dated 04/21/05
- Winston Whitt, M.D.: Consultation Note dated 04/19/05
- Horizon MRI of Lubbock: MRI lumbar spine dated 04/11/05, MRI cervical spine dated 04/14/05
- Coolbaugh Chiropractic: Office notes dated 04/06/05 through 05/04/05 from Robert Coolbaugh, D.C.
- Worker's Compensation Initial Evaluation Report dated 04/05/05 from Robert Coolbaugh, D.C.

The reviewing provider is a **Licensed/Boarded Orthopedic Surgeon** and certifies that no known conflict of interest exists between the reviewing **Orthopedic Surgeon** 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 prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.

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.

This decision is deemed received by you 5 (five) days after it was mailed (28Tex.Admin. Code 102.4(h)(2) or 102.5(d)). A request for a hearing **and a copy of this decision** should be sent to:

Chief Clerk of Proceedings / Appeals Clerk
Texas Department of Insurance Division of Workers' Compensation
P.O. Box 17787
Austin, Texas, 78744
Fax: 512-804-4011

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

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U. S. Postal Service from the office of the IRO on this

14th day of February 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____