



CompPartners Final Report



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO # : _____
MDR #: M2-06-1075-01
Social Security #: _____
Treating Provider: James Key, MD
Review: Chart
State: TX
Date Completed: 4/24/06

Review Data:

- **Notification of IRO Assignment dated 4/10/06, 1 page.**
- **Receipt of Request dated 4/7/06, 1 page.**
- **Medical Dispute Resolution Request/ Response dated 3/20/06, 2 pages.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **Notice of Utilization Review Findings dated 3/13/06, 2/28/06, 4 pages.**
- **Follow-up Medical Evaluation dated 2/10/06, 4 pages.**
- **Examination dated 12/16/05, 3 pages.**
- **Chart Review dated 8/2/05, 2 pages.**
- **Follow-up Visit dated 7/22/05, 2 pages.**
- **Lumbar Spine MRI dated 10/21/05, 2 pages.**
- **Lumbar Spine CT Scan dated 1/19/05, 2 pages.**
- **Office Visit dated 2/23/05, 2 pages.**
- **Independent Medical Evaluation dated 4/2/04, 9 pages.**
- **Case Review dated 4/30/04, 2 pages.**
- **Medical Examination dated 5/4/05, 5 pages.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for L4-5 and L5-S1 posterolateral fusion with posterior segmental instrumentation, cages.

Determination: REVERSED - the previously denied request for L4-5 and L5-S1 posterolateral fusion with posterior segmental instrumentation, cages.

Rationale:

Patient's age: 37 years

Gender: Male

Date of Injury: _____

Mechanism of Injury: While operating a forklift at the back of a truck, the truck moved and the forklift fell between the truck and the dock.

Diagnoses:

Rotator cuff sprain.
Intervertebral disc displacement with myelopathy and lumbar radiculopathy.

The claimant was injured when his forklift fell off the back of a truck. Records begin on 04/02/04, with an Independent Medical Evaluation with Dr. Whitsell. The claimant reported cervical, right shoulder and low back pain. He had undergone right shoulder surgery in 2003, with some improvement. Dr. Whitsell evaluated the cervical spine and right shoulder, but the low back was the claimant's main pain focus. The physician noted that a lumbar MRI showed a disc protrusion at L4-5, without nerve root compromise, although the date of the study was not provided. On examination, there was diminished lumbar motion. The claimant was able to heel and toe walk, but strength testing was difficult due to pain and decreased motion. Sensation was intact and reflexes symmetrical. He opined that the lumbar spine had not resolved, and that the claimant should have an orthopedic evaluation. The claimant had a CT scan and discogram on 01/19/05. The test showed a full thickness tear at L4-5 and multiple full thickness tears at L5-S1.

Following that study, an inpatient fusion at L4-5 and L5-S1 was recommended, but not authorized. Dr. Hershkowitz reviewed the discogram and did not feel that the leakage was significant and that surgery, based on that study, was not indicated. On 05/04/05, Dr. Sanders evaluated the claimant for a Required Medical Examination (RME). On examination, there was a normal gait. Examination of the cervical spine was unremarkable. The low back was tender to light touch, with restricted motion. Dr. Sanders opined that the claimant had a lumbar strain superimposed on degenerative change, and that the strain had resolved. He further noted that surgery was not indicated. An MRI of the lumbar spine was performed on 10/21/05, and showed a disc protrusion and flattening of the origin of both proximal L5 nerve roots and degenerative retrolisthesis of L5 to S1 and a posterior disc protrusion and encroachment of the L5 roots.

On 12/16/05 Dr. Roman evaluated the claimant for low back pain and bilateral leg pain, with numbness and tingling. His impression was intervertebral disc displacement with myelopathy and lumbar radiculitis, and referral to Dr. Key was recommended. On follow-up with Dr. Roman on 02/10/06, the examination revealed diffuse paravertebral pain and spasm, positive straight leg raising bilaterally at 30 degrees, decreased motor strength in the great toes and quadriceps and hamstring weakness. The Achilles reflexes were decreased bilaterally, and there was decreased sensation in the L5-S1 region. The claimant was referred to Dr. Key and a request for L4-5 and L5-S1 fusion was made. The request for fusion had been denied and the denial has been appealed. It appears from this medical record that the claimant had been having back complaints since May 2003. The early records document back and leg complaints, yet there was no evidence of a neurologic deficit, disuse muscle atrophy, protective muscle spasm or any obvious loss of function. The initial MRI reported in a 04/02/04 office note of Dr. Whitsell, seemed to show an L4-5 disc protrusion without nerve root compromise. There was then a January 2005 CT discogram of the lumbar spine, which documented tearing of the L4-5 and L5-S1 disc, yet there was no discussion in this report of documented correlating pain complaints.

In August 2005, the records of Dr. Jennings documented a new change in the claimant's condition, because Dr. Jennings described a neurologic deficit with muscle weakness, loss of sensation, and abnormal reflexes; this is the first time in any of the medical records that a neurologic deficit has been described. A 10/21/05 MRI of the lumbar spine, documented L4-5 and L5-S1 disc changes, with apparent nerve root impingement at L5 bilaterally, and follow-up

office notes of Dr. Roman described protective muscle spasm, positive straight leg raising, and neurologic deficit to include decreased strength, reflex change and decreased sensation. Also, the diagnosis was changed from one of back and leg pain, to disc displacement with myelopathy. It was obvious the physicians treating this claimant had changed their documentation in reference to physical findings since initially, the claimant had complaints of pain without positive physical findings, and now the claimant has positive physical findings and a diagnosis of myelopathy.

It appeared from this medical record the claimant's treating physicians felt that there was an impinging lesion causing the myelopathy and requested decompressive surgery with fusion and this reviewer assumes the purpose of the fusion was to stabilize the area after they had done a wide decompression, to decrease the risk of instability or other problems in the future. This record did not document an infection or a destructive bony lesion, nor did it document a functional instability. However, there was a description of a retrolisthesis of the lower lumbar spine, which was not described previously and therefore, more than likely as the discs are degenerating further, this is probably becoming more unstable.

In light of the fact the claimant's physicians are now documenting a progressive neurologic deficit and the claimant now carries a diagnosis of myelopathy, then clearly, an operative procedure would be appropriate to try and decompress the affected area. The requested fusion procedure would be related in that, the treating physicians are planning a wide decompression which may, in fact, further destabilize the area, necessitating the fusion portion of the operative procedure. A three-day length of stay is reasonable for this type of procedure. In retrospect, the previous request for surgery, this reviewer believes the denials were appropriate in that the claimant had only pain complaints, without evidence of a neurologic deficit, protective muscle spasm or structural instability, but his treating physicians have clearly changed their documentation indicating a current diagnosis of myelopathy, with a progressive neurologic deficit, change in position on the MRI, and protective spasm which would make their requested surgery medically reasonable at this time.

Criteria/Guidelines utilized: ACOEM Guidelines, 2nd Edition, Chapter 12.
Official Disability Guidelines: TWC Low Back; pg 814.

Physician Reviewers Specialty: Orthopedic Surgery

Physician Reviewers Qualifications: Texas Licensed M.D. and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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.