

August 30, 2006

TX DEPT OF INS DIV OF WC  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_

EMPLOYEE: \_\_\_

POLICY: M2-06-1754-01

CLIENT TRACKING NUMBER: M2-06-1754-01

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Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing 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.

**Records Received:**

RECORDS RECEIVED FROM THE STATE:

Notification of IRO Assignment dated 8/8/06, 14 pages

RECORDS RECEIVED FROM THE RESPONDENT:

Work status reports 2 pages

Treatment Records of Donald Hund, 12/4/03-4/7/04, 69 pages

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MRI Lumbar Spine dated 12/23/03, 2 pages  
Letter from Dr. Cannon dated 1/22/04, 6/22/04, 4/26/05, 11 pages  
Cervical spine report dated 1/22/04, 1 page  
Texas Workers Compensation Work Status Report, 4=5 pages  
Letter from Dr. Strausser dated 2/4/04, 3/25/04, 6/7/04, 7/1/04, 7/26/04, 9/3/04, 10/11/04, 11/29/04, 12/21/04, 1/18/05, 3/1/05, 4/12/05, 27 pages  
Letter from Dr. Nelson dated 3/2/04, 5 pages  
Medical Records Dr. Carl Cannon, 4/8/04–4/26/04, 3 pages  
EMG/NCV Study dated 01/27/04, 1 page  
Medical records, Dr Samuel, 7 pages  
MRI cervical spine, 6/29/04, 2 pages  
Operative Report dated 05/19/04, 2 pages  
Anesthesia record, 5/19/04, 2 pages  
Radiology report, 5/19/04, 1 page  
EMG/NCV Study dated 07/07/04, 2 pages  
Physical Therapy Records, 49 pages  
Medical Records Dr. Lenny Jue, 3 pages  
Procedure Report dated 08/02/04, 2 pages  
Anesthesia report 8/2/04, 1 page  
CT Cervical Spine and cervical myelogram dated 09/23/04, 4 pages  
Operative Report and physician orders, etc dated 12/07/04, 18 pages  
Labs, 12/3/04, 4 pages  
Neurophysiologic Monitoring Report, 12/7/04, 1 page  
Admission records from 12/7/04, 33 pages  
Letter from Dr. Whitsell dated 1/29/05, 1 page  
Report of Medical Evaluation, 4 pages  
Functional Capacity Evaluation dated 11/17/03, 14 pages  
Impairment Rating dated 04/26/05, 2 pages  
MRI Lumbar Spine dated 10/04/05, 2 pages  
Physician Advisor Review dated 10/27/05, 3 pages  
Impairment Rating dated 11/01/05, 2 pages  
Medical Records Dr. Douglas Stauch  
Functional Capacity Evaluation dated 01/06/06, 14 pages

### **Summary of Treatment/Case History:**

The patient is a 57 year old male who reportedly sustained injuries to both the cervical and lumbar spines on \_\_\_\_\_. On this date the patient was the operator of an 18-wheeled motor vehicle that was struck in the side by a second vehicle. The record does not contain any information in regards to the accident, the type of second vehicle or the speed of the vehicles involved.

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The record begins on 12/04/03. The patient sought care from Donald Hund, D.C. The record indicates that the patient at the time reported 8 out of 10 pain localized to the cervical and lumbar spines with radiation into the left buttocks. The patient received extensive chiropractic care from Dr. Hund and was later referred for MRI of the lumbar spine on 12/23/03.

This study reports a previous left-sided hemilaminectomy defect seen at L5-S1 with mild anterolisthesis at the postoperative levels of L5 and S1 of approximately 2-3 mm. There is normal alignment otherwise with a high intensity zone disc seen at L5-S1. There is disc desiccation without loss of height at L4-5. Specifically, at L4-5 there is a bulging anulus of 2-3 mm. This is accompanied by epidural lipomatosis and does not appear to exhibit mass-effect especially dorsally on the thecal sac resulting in a trefoil appearance with central stenosis of moderate degree. There is accompanying facet arthropathy of a mild degree. There is lateral recess narrowing of a small to moderated degree in addition to biforaminal encroachment without deformity of either L4 nerve root sleeve in its neural foramen. At L5-S1 post surgical changes are noted. There is a left-sided laminectomy defect noted with a non enhancing left foraminal protrusion association with high intensity zone disc of 6 mm significantly deforming the left L5 nerve root sleeve which is clearly superiorly displaced in its neural foramen.

The patient was referred to Dr. Carl Cannon on 01/22/04. At this time the patient reports low back pain with radiation into the left thigh only. On physical examination of the lumbar spine there is a diminished left ankle jerk reflex. Strength in the lower extremities is symmetrical. Bilateral sitting straight leg raise is positive for left posterior leg pain. Dr. Cannon reports that the patient is status post a previous lumbar spine surgery on 12/08/98 performed by Dr. Windenberg which was a left L5-S1 hemilaminectomy, medial fasciectomy, and foraminotomy with removal of a herniated nucleus pulposus. The patient later underwent a second surgery for a recurrent disc herniation at L5-S1 on 01/2000.

The patient was referred to Dr. David Strausser for consultation and consideration of operative intervention. The patient was referred for EMG on 01/27/04. This study indicates a left S1 radiculopathy. The patient was seen by Dr. Strausser on 02/02/04. On physical examination the patient is noted to have a small midline incision at L5-S1. There are no paravertebral muscle spasms. He has moderate tenderness over the left L5-S1 facet joint and in the left sciatic notch region. The patient has limited lumbar range of motion. There is no evidence of atrophy in the lower extremities. Motor strength is rated as 4/5 in the left EHL; otherwise, motor strength is intact. Sensation to light touch is intact. Reflexes at the quadriceps are symmetric and absent in the left Achilles. Straight leg test is negative. Nerve root stretch is positive on the left at 45 degrees. Dr. Strausser recommends a left L4-5 and L5-S1 re exploration laminectomy, discectomy and decompression secondary to lateral recess stenosis on the left at L4-5 and L5-S1.

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He opines that epidural steroid injections would be of little benefit given the fact that the patient is post-operative.

The patient was referred to Dr. Page Nelson on 03/02/04. At this time Dr. Nelson performed a second opinion and concurred that the patient would most likely benefit from a decompression of the L5 and S1 nerve roots. The patient was seen by Dr. Strausser on 03/25/04. At this time he is declared refractory to conservative care and operative planning was performed. The patient was taken to surgery on 05/19/04. At this time Dr. Strausser performed a left L4-5 and L5/S1 re exploration, hemilaminectomy, lateral recess decompression, medial facetectomy, and foraminotomy.

The patient was seen in follow up on 06/07/04. He is reported to be three weeks status post surgery and had excellent relief of his pain with this procedure. The patient was recommended to start aquatic therapy to be later followed by land-based therapy. On 06/22/04 the patient was seen by Dr. Cannon and at this time he reports continued cervical pain. Dr. Cannon initiates an evaluation of the patient's cervical complaints and recommends that the patient be referred to Dr. Strausser. The patient was referred for MRI of the cervical spine on 06/29/04. The patient was later evaluated by Dr. Strausser on 07/01/04. He was again referred for EMG studies on 07/07/04 which indicated bilateral C6 radiculopathies.

The patient underwent a single cervical epidural steroid injection on 08/02/04. This failed to provide the patient any significant relief and it was recommended that he undergo cervical surgery. The patient was again taken to surgery on 12/07/04 and at this time Dr. Strausser performed a two-level ACDF with instrumentation. Postoperatively the patient did very well until 03/01/05. At this time he is reported to be fourteen weeks status post two-level ACDF with some increased pain in the left trapezius and periscapular regions with some paresthesia in the proximal arm.

The patient was later referred for a functional capacity evaluation on 04/08/05. This report indicates that the patient was capable of a medium physical demand level and his job required a heavy physical demand level. The patient was discharged from care on 04/26/05. At this time the patient reports that he is about 75 % improved overall. He is currently without any radicular symptoms. His lower extremity reflexes are 2+. His EHL and ankle dorsiflexors are intact. There is no calf atrophy. The upper extremities are noted to be within normal limits.

The patient was evaluated and impaired by Dr. Cannon on 04/26/05. Dr. Cannon found the patient to have a 33% whole person impairment rating. On 05/06/05 the patient expressed a desire to return to work and he was given a medium duty release.

On 09/06/05 the patient again sought care from Dr. Carl Cannon secondary to recurrent cervical pain with radiculopathy and recurrent lumbar spine symptoms with radiculopathy. Examination of the lumbar spine reveals 2+ ankle jerks at the knees. His EHL and ankle dorsiflexors are intact. The straight leg test is negative and there is no noted calf atrophy. In regards to the patient's cervical spine, he has 2+ upper extremity reflexes in the biceps, triceps and brachioradialis. There is mild left deltoid weakness. He is otherwise normal.

The patient was seen by Dr. Strausser on 09/13/05. At this time the patient reports that he has recurrent left-sided low back pain, posterior hip pain with a burning tingling sensation along the lateral thigh stopping at the knee. The patient reports that the pain is not incapacitating. On physical exam the patient has a normal gait; there is no tenderness to palpation; he has a well-healed midline incision; mild tenderness is noted in the left sciatic notch region; and he has normal lumbar range of motion in the upright position. Motor strength testing reveals 4+/5 weakness in the left EHL. Otherwise, motor strength is intact. Reflexes are symmetric at the quadriceps and Achilles. Nerve root stretch is negative.

The patient was referred for MRI with and without contrast on 10/04/05. This study reports a shallow recurrent left posterior lateral disc protrusion at L5-S1 that impinges slightly on the left S1 nerve root within the spinal canal. There is no evidence of a recurrent disc herniation at the L4-L5 level. There is bilateral facet joint hypertrophy producing mild inferior narrowing of the neural foramina at the L5-S1 level without associated impingement on the exiting L5 nerve roots. There is significant reactive epidural fibrosis producing cicatrization and distortion of the epidural space caudal to the L4-5 disc level as well as left-sided perineural fibrosis at both L4-5 and L5-S1 levels. There are postoperative changes associated with left-sided laminectomies at L4-5 and L5-S1. There is a congenitally narrow lumbar spinal canal.

The patient was again seen by Dr. Strausser on 10/07/05. At this time his examination is unchanged. The MRI findings were reviewed. Dr. Strausser indicates that an injection is most likely not going to be beneficial. He recommends trying to avoid additional surgery, if possible, and he reports that the patient will be moving out of the immediate area. He opines that if the patient's systems worsen, consideration may be given to a lumbar CT discogram at L3-4, L4-5 and L5-S1. He further indicates that the patient most likely will require at a minimum an L5-S1 fusion with potential fusion at the L4-5 level.

The patient was seen by Dr. Roger Moczygemba, a designated doctor, on 11/01/05. Dr. Moczygemba opines that the patient is at clinical Maximum Medical Improvement and assessed the patient at a 33% Whole Person Impairment Rating. On 01/06/06 the patient was referred to Dr. Douglas Stauch for a required medical examination. Dr. Stauch performed an extensive examination of the patient. Examination of the lumbar spine reports that the patient's gait was

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satisfactory. He was able to stand on his toes and heels without difficulty. There is some left paraspinal lumbar spasm. There is no tenderness to palpation of the paraspinal muscles. Patient has reports of pain with axial compression. There is tenderness over the left sciatic notch and over the lower lumbar spinous process. The lower extremity measurements were normal and symmetric with no evidence of atrophy. The remainder of the patient's physical exam cannot be documented; page ten of the report is missing. Dr. Stauch opines that the patient requires minimal maintenance care and indicates that the patient would be capable of returning to work at a light duty status.

The patient later performed an FCE and was felt to be capable of a medium physical demand level. The patient was seen by Dr. Strausser on 01/27/06. He reports that the patient most likely will remain off work indefinitely. The patient was again seen by Dr. Strausser on 04/28/06. At this time the patient still has a significant amount of low back pain. The patient reports having difficulty doing activities during the day. He continues to complain of numbness in his left lower extremity and overall feels like his condition is worsening. On physical exam the patient has 4/5 weakness of the left EHL, otherwise motor strength is intact. Reflexes are reported to be symmetric at the quadriceps and Achilles. The nerve root stretch test is negative. It was recommended that the patient undergo a CT discogram at L3-4, L4-5 and L5-S1 to better assess which specific level is leading to his continued low back pain. It is indicated that this request is for operative planning and that an L5-S1 fusion would be considered and potentially extended to the L4-5 level depending upon the results of discography.

#### **Questions for Review:**

1. Pre auth denied for repeat lumbar CT discogram L3-4, L4-5 and L5-S1. Please review for medical necessity.

#### **Explanation of Findings:**

1. Pre auth denied for repeat lumbar CT discogram L3-4, L4-5 and L5-S1. Please review for medical necessity.

The proposed CT discogram at L3-4, L4-5 and L5-S1 is not medically necessary. The medical records as presented do not indicate that the patient has previously undergone discography. The available studies developing stenosis and fibrosis at L4/5 and L5/S1 as well as a probable recurrent disc herniation at L5/S1 with possible impingement on the left S1 nerve root. Discography is unlikely to provide substantial information for surgical planning. Heggeness et. al. report "Patients presenting with disabling back pain who had previously undergone surgical treatment for a herniated nucleus pulposus show a high (72%) incidence of concordant pain with discography of the previously operated level. Only 34% of the previously operated discs demonstrated posterior extravasation of discography dye. Persistence of a posterior anular defect was associated with a higher incidence of positive concordant pain response".

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**Conclusion/Decision to Not Certify:**

The proposed CT discogram at L3-4, L4-5 and L5-S1 is not medically necessary.

**References Used in Support of Decision:**

1. Discography of Lumbar Discs After Surgical Treatment for Disc Herniation. Spine. 22(14): 1606-1609, July 15, 1997. Heggeness, Michael H. MD, PhD; Watters, William C. III, MD; Gray, P. Milton Jr MD.
2. The Official Disability Guidelines, 11th edition, The Work Loss Data Institute. Accessed: 08/30/2006.

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The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

**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.

Chief Clerk of Proceedings/Appeals Clerk  
P. O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. 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 Division 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.

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Postal Service from the office of the IRO on this 31 day of Aug/2006.

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Stacie Sterken

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

1250415.1

Case Analyst: Stacie S ext 577

cc: Requestor  
Respondent