



Specialty Independent Review Organization, Inc.

October 10, 2006

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

Patient: ____
DWC #: ____
MDR Tracking #: M2-06-1847-01
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. ____ was working as an order puller when she was injured on _____. According to the employer's first report of injury or illness, which was completed by Dr. A. J. Morris, Ms. ____ walked into an open file cabinet and cut her nose. Dr. Morris' initial medical report indicates that she was seen on April 23, 2003, 2 days after the injury. She had report of a facial trauma with contusions, laceration of her nose and a fall. She stated that she fell onto her back and was dazed and may have lost consciousness. Dr. Morris' initial physical examination consisted only of vital signs. He made no comment whatsoever about her facial, head injuries, neck, back or extremities. He did not document a neurologic examination. The impression was "facial trauma/head trauma with loss of consciousness, post concussion syndrome with photophobia, and facial contusion." He referred her to a specialist for a TMJ evaluation and an ophthalmologist. He prescribed Trazodone and Lortab. There were no notes submitted

regarding her TMJ evaluation, however, she was seen by an ophthalmologist Dr. Robert Warren on 05-27-03, approximately one month after her accident. She complained to Dr. Warren of headaches and occasional diplopia with tearing, sharp pain in and around her right eye. There was no evidence of ocular involvement according to Dr. Warren's notes. She was noted to have some small residual subcutaneous hematoma around her right eye with no step-off and no tenderness to touch.

Dr. Morris continued to treat Ms. ___ and referred her to an associate within his practice, Dr. Ed Cerday, a pain management specialist beginning in August 2003 because of headaches, right upper jaw pain and "recurring problems". Dr. Cerday's initial evaluation showed decreased neck rotation to the right due to cervical pain and tight and tender cervical muscles, right greater than left. He did not document a detailed neurologic examination. His impression was cervical strain/sprain, suspect disk problems, post concussion headaches/syndrome and "believes headaches part of cervical spine problem as well as jaw pain". Dr. Cerday recommended an MRI of the cervical spine and to review an MRI of the brain ordered by Dr. Morris and suggested possible injections. The C-spine MRI was done on 08-27-03 and it showed a mild to moderate disk desiccation and right focal paracentral disk protrusion and herniation measuring approximately 11 mm transverse by 5 mm anterior/posterior at C4-5. The disk protrusion severely attenuated the anterior subarachnoid space and contacted and moderately deformed the ventral aspect of the spinal cord on the right. There was resultant spinal stenosis on the right with residual AP spinal canal measuring 8.0 mm. There was also moderate stenosis to the right lateral recess and to a lesser extent the right neuroforamen. The left neuroforamen appeared ample. At C6-7 there was moderate disk desiccation with a large broad base central disk protrusion and probable herniation measuring approximately 15 mm transverse by 5 mm AP. Again, there was deformation of the ventral aspect of the chord with resultant spinal canal stenosis with the residual AP spinal canal measuring approximately 6 mm and mild stenosis lateral recesses bilaterally. At C6-7 there was moderate disk desiccation along with right focal paracentral disk protrusion and possible herniation measuring approximately 8.0 mm transverse by 3.0 mm AP. This attenuated the anterior subarachnoid space and minimally deformed the ventral aspect of the spinal cord on the right. There was resultant stenosis on the right with residual AP spinal canal measuring 8.0 mm and mild stenosis of the right lateral recess and moderate stenosis of the bilateral neuroforamen secondary to ongoing vertebral spurring. The C7-T1 level was normal. The previously mentioned brain MRI study was not submitted.

Dr. Cerday treated Ms. ___ for the next several years with a combination of chronic opioid therapy, trigger point injections and muscle relaxants. There was no formal referral to physical therapy or chronic pain management. There were no cervical epidural injections performed.

Ms. ___ was seen by a neurosurgeon, Dr. Diana Wilson on 04-28-04 at the referral of Dr. Morris, her primary treating physician. Dr. Wilson stated that several days after her accident she noted pain and stiffness in her neck. At some point thereafter, she started to have pain in her right shoulder blade and interscapular area which was burning and tingling at that time. The neck pain radiated into the right arm, forearm and hand and was sharp and stabbing in character. She complained of numbness and heaviness in the right arm. Dr. Wilson's examination disclosed weakness in the right, greater than left upper extremities with brisk lower extremity reflexes but

absent Babinski signs. She also reported that there was decreased sensation in the right C5-C7 dermatomes. On gait testing she had decreased associated arm movements and was unsteady with tandem gait. Dr. Wilson wanted to obtain flexion extension views of her neck to rule out subluxation. She eventually recommended multilevel cervical fusion and corpectomy.

Ms. ___ underwent numerous independent medical examinations plus her records underwent a variety of peer reviews. She had an IME done on 08-22-03 by Phillip Osborne, MD, but the report submitted was incomplete as it only included her history. There were no physical findings, impression or recommendations submitted. An addendum dated 10-02-03 was submitted in which Dr. Osborne felt that the complaint of pain in Ms. ___'s nose, mouth, ear, back and teeth could be related to her neck pathology and "this being the case I feel the cervical spine could be related to the trauma in question". He recommended an RME by a board certified orthopedic surgeon. He did not feel that any findings on the brain MRI were related to any trauma.

An orthopedic IME was performed by Dr. William H. Mitchell on 09-28-04. He noted on examination that she had an absent right triceps reflex with weakness of the right triceps. He did not do a sensory examination. Dr. Mitchell's opinion was that the complaints of neck pain were due to the April 21, 2003 injury because she had no previous history of neck problems or arm pain and this began the day following the injury. He recommended that she have a myelogram CT and an EMG and he agreed with proposed surgery although he does not describe the procedure that Dr. Wilson has recommended.

Dr. Charles Crane, a physiatrist, performed a medical record review on January 28, 2005 in which he felt that the cervical disk disease was not a direct result of the injury and that the documentation did not support the conclusion that there was a causal relationship. He felt that the degenerative disk disease may have been pre-existing or part of ordinary disease of life.

Dr. Jerry McShane submitted a medical evaluation on June 30, 2004 which initially encompassed only the facial trauma. He felt that there was no permanent impairment as a result of the compensable injury and that she had reached maximum medical improvement as of June 30, 2004 regarding her facial injuries. However, Dr. McShane then submitted another report dated March 14, 2005 in which he stated that since the last visit with Ms. ___ on 06-30-04 the insurance company has taken responsibility for the cervical injury. In his opinion, Ms. ___ was a candidate for cervical disk surgery and that "both physical examinations as well as diagnostic testing support this position". In my opinion, surgery should be approved and carried out ASAP to prevent nerve damage". On May 20, 2005, he stated that she had reached MMI as of 04-19-05 that she belonged in Category III, i.e. that she has evidence of cervical disk disease with associated symptoms. He wrote a letter of clarification on June 9, 2005 stating that the only piece of information that may be helpful in this case was an EMG and nerve conduction studies of the upper extremities.

A peer review was performed by Benjamin Agana, a physiatrist on September 21, 2005. Dr. Agana felt that there was no definite cause and relationship between the claimant's injury and the three disk herniations in the neck based upon her initial complaints which were facial in nature.

He stated that she likely sustained a cervical sprain. He stated "it is a matter of speculation whether or not this is a manifestation and result of the compensable injury. It is possible that this could be the result of the injury but not entirely probable for the reason stated above. I do feel that the patient definitely needs further treatment because of subsequent examinations indicating radiculopathy and weakness of the arms and myelopathy. Surgical decompression is required; however, it is yet to be determined whether or not this is all the result of a compensable injury or a separate condition altogether that requires treatment nonetheless".

Dorothy Leong, also a physiatrist, submitted a medical record review dated September 28, 2005 indicating that the designated doctor's examination had noted a 15 percent whole person impairment rating, however, given the findings of the EMG nerve conduction studies which showed a chronic rather than acute radiculopathy, and that she had a normal neurologic examination per the chiropractor who performed the EMG and nerve conduction studies with no evidence of muscle atrophy, Dr. Leong opined that she had a 5 percent whole person impairment.

Dr. Hooman Sedighi, also a physiatrist, submitted an IME on 11-09-05. He stated that the patient reported having had neck pain to Dr. Morris but there was no documentation of neck symptoms by Dr. Morris in his initial evaluation. Dr. Sedighi felt that Ms. ___'s clinical examination findings and history and EMG findings were consistent with a chronic C6 radiculopathy and he recommended a CT myelogram and a cervical epidural injections before proceeding with surgery plus referral to an independent licensed physical therapist with special expertise in manual therapy and McKenzie extension protocol. Dr. Sedighi submitted a required medical examination on 07-12-06 indicating that Ms. ___ was having continued problems and had not had the recommended therapy in an independent physical therapy clinic. He stated that a video disk showed Ms. ___ performing various activities on 05-04-06 and appeared to have functional cervical ROM. He felt that the patient should have been able to return to work at a least a light duty level with avoidance of any awkward positioning of the cervical spine. She was never sent for the CT myelogram and was on escalating doses of OxyContin and was now on Oxy IR for breakthrough pain. Dr. Wilson the neurosurgeon wished to proceed with surgery apparently without obtaining a CT myelogram for better evaluation of the cervical spine. He recommended again that she have a CT myelogram and return to work at a light duty level.

Imaging studies submitted included facial bone x-rays performed on 06-23-03 which showed a non-displaced fracture of the right nasal bone associated with reactive hyperemia and localized remodeling of bone associated with minimal thickening and deformity and resolving some cutaneous hematoma and normal paranasal sinuses and deviation of the nasal septum to the left. There was no evidence of a skull fracture. A CT of the brain dated 06-23-03 was negative. An MRI of the brain dated 08-27-03 was previously discussed. X-rays of the cervical spine dated 04-28-04 showed no subluxation but there were degenerative changes noted at C5-6. An MRI of the cervical spine without contrast on 07-23-04 showed findings similar to the 08-27-03 MRI with multilevel degenerative disk changes at C4-5, C5-6 and C6-7, particularly at C6-7 where there was moderate cord compression. Another MRI of the cervical spine done on 05-11-05 showed again fairly significant degenerative changes at C4-5, C5-6 and C6-7 with evidence of spinal cord deformity at C6-7.

A CT myelogram done on August 28, 2006 showed a 3.0 to 4.0 mm right lateral recess and right paracentral disk protrusion indenting the spinal cord to a moderate degree resulting in a mild to moderate degree of central spinal canal stenosis. There were small marginal osteophytes noted but no foraminal stenosis. At C5-6 there was a 3.0 to 4.0 mm posterior osteophytic ridge or possible calcified herniated nucleus pulposus. Bone indented the spinal cord a moderate degree and resulted in a moderate to severe degree central spinal canal stenosis with an AP diameter of 5 to 6 cm. The foramina were clear. At C6-7 there was a 3.0 to 4.0 mm right and posterior marginal osteophytic ridge that indented the spinal cord a moderate degree resulting in a moderate degree of central canal stenosis with an AP diameter of 6.0 mm.

An EMG and nerve conduction studies done by a chiropractor J. B. Brock on 07-27-05 was read as consistent with mild bilateral carpal tunnel syndrome, left worse than right and mild chronic bilateral C7 radiculopathies.

RECORDS REVIEWED

- 1) Correspondence to Diana Wilson, MD from CorVel Corporation dated 03-20-06 and 06-23-06.
- 2) Employer job duties verification form from Chub Insurance.
- 3) Job description by Stuart Title, North Texas dated 12-02.
- 4) Employer's first report of injury and illness office progress notes and correspondence and TWCC work status reports by A. J. Morris, MD dated 04-23-03 thru 04-13-04.
- 5) Office progress notes, procedure notes, TWCC work status reports and correspondence, Ed Cerday, MD dated 08-20-03 thru 08-24-06.
- 6) Office progress notes and correspondence, Diana Wilson, MD dated 04-24-04 thru 05-19-05.
- 7) Office progress notes and TWCC work status reports by Robert Warren, MD dated 05-27-03 to 06-27-03.
- 8) IME by Phillip Osborne, MD dated 08-22-03 with review of additional medical records dated 10-02-03.
- 9) Peer Review Summary, authorship unknown dated 09-30-03.
- 10) Orthopedic IME by William H. Mitchell, MD dated 09-28-04.
- 11) Medical Record Review by Charles Crane, MD dated 01-28-05.
- 12) Reports of medical evaluation by Jerry McShane, DO dated 06-30-04 thru 06-09-05.
- 13) Peer Review by Benjamin Agana, MD dated 09-21-05.
- 14) Medical Record Review by Dorothy Leong, MD dated 09-28-05.
- 15) Independent Medical Examination and required examination by Hooman Sedighi, MD dated 11-09-05 thru 07-12-06.
- 16) Chiropractic EMG and nerve conduction studies by J. B. Brock, DC dated 07-27-05.
- 17) Correspondence addressed to Specialty IRO by John V. Fundus, Attorney at Law dated 09-21-06.
- 18) Multiple miscellaneous imaging studies.

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of an anterior cervical corpectomy and fusion @ C6 and C6 corpectomy. LOS x1 day.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer states that Ms. ____ has not received maximal conservative therapy for her condition. She has been treated with oral analgesic medications and muscle relaxants and trigger point injections. She has not received adequate trials of physical therapy. She has not had cervical epidural steroid injections or nerve root blocks. These programs should be initiated prior to the consideration of a surgical procedure. Her EMG study is not suggestive of active denervation in her C6 or C7 innervated muscles.

REFERENCES

American College of Occupational and Environmental Medicine, Occupational Medicine Guidelines, 2nd edition, 2004.

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 Division via facsimile, U.S. Postal Service or both on this 10th day of October 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli