IMED, INC.

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NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE:
IRO TRACKING NUMBER: M2-06-1863-01
NAME OF REQUESTOR: Jacob Rosenstein
NAME OF CARRIER: Parker & Associates for TACWC Self Insured Fund
DATE OF REPORT: 09/12/06
IRO CERTIFICATE NUMBER: 5320

TRANSMITTED VIA FAX:

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cased to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by an M.D. physician reviewer who is Board Certified in the area of Neurosurgery and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, Inc., and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the provider, the injured employee, 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 Independent Review Organization. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

REVIEWER REPORT

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

Information Provided for Review:

1. X-ray cervical spine dated 01/15/03.
2. Employer's First Report of Injury or Illness.
3. Medical records from Dr. Lee Kesterson.
4. MRI cervical spine dated 02/13/03.
5. Cervical myelogram dated 03/24/03.
6. Operative report dated 04/14/03.
7. Medical records from Dr. Patrick Donovan.
8. EMG/NCV dated 10/17/04.
9. Procedure reports.
10. Medical records from Dr. Jacob Rosestein.
11. Treatment records from High Pointe Rehabilitation Institute.
12. Cervical myelogram dated 01/18/06.
13. Cervical discogram dated 06/06/06.
14. Functional Capacity Evaluation.
15. Physical therapy records.

Clinical History Summarized:

The employee was reported to have sustained an injury to his neck on ___ while operating a road paving piece of equipment that struck a buried pipe in the ground. This caused the vehicle to jump up and down, resulting in the employee sustaining a flexion and extension injury to the cervical spine.

The employee was initially evaluated at the Campbell Memorial Hospital in Weatherford, Texas. X-rays were obtained, which indicated mild anterior degenerative spurring changes at C5-C6.

The employee was later referred for an MRI of the cervical spine on 01/27/03, which revealed no evidence of herniation at C2-C3 or C3-C4. At C4-C5, there was a 2 mm central disc protrusion which narrowed the anterior subarachnoid space and touched the ventral surface of the spinal cord. The neural foramina was patent. At C5-C6, there was a 3 mm broad disc protrusion which caused mild central canal stenosis touching the ventral surface of the spinal cord. The anterior subarachnoid space was narrowed. There was mild left neural foraminal narrowing due to the protrusion and facet hypertrophy. At C6-C7, there was a 3 mm broad disc protrusion which narrowed the anterior subarachnoid space but caused no significant central canal stenosis. There was mild left neural foraminal narrowing due to the prot5rusi0on and facet hypertrophy.

The employee was seen by Dr. John Stasikowski on 01/28/03. The employee reported significant cervical pain made worse by putting the left arm down. The employee reported two

episodes of left thumb numbness and tingling. The employee's past medical history was positive for three lumbar spine operative procedures performed by D. J. Gaines and Dr. P. Bechtel. Upon physical examination, cervical range of motion was diminished, and the employee reported discomfort on flexion. There was paracervical muscle spasm. Spurling's maneuver was equivocal bilaterally. Upper extremity motor strength was reduced in the left triceps. There was no evidence of atrophy or sensory deficits. Reflexes were 1+ in the biceps bilaterally and trace in the triceps bilaterally. Hoffman sign was negative. Examination of the left shoulder revealed full active range of motion with a negative impingement sign. The employee was referred to Dr. Lee Kesterson on 02/04/03.

Dr. Kesterson noted the above history. Upon physical examination, motor strength was intact in all muscle groups; however, Dr. Kesterson noted some giveaway weakness on the left side. There was a decreased sensory perception in the left C6 dermatome. There was a positive Tinel's at the left elbow, but negative at the wrist, and a negative Phalen's at the wrist. Reflexes were 2+ and symmetric. Dr. Kesterson opined that the employee had a left C6 radiculopathy and recommended cervical epidural steroid injections and suggested EMGs. The employee received a single epidural steroid injection, which provided no sustained relief.

The employee was later referred for a cervical myelogram on 03/24/03. This study reported a few levels of mild anterior encroachment on the thecal sac more prominent at the C5-C6 and C6-C7 disc levels. At each of these levels there also appeared to be a decrease in nerve root sleeve filling, and underlying neural foraminal stenosis may be present. A significant degree of spinal canal stenosis did not appear to be present at this examination. The post myelogram CT indicated multiple levels of mild to moderate spondylosis of the cervical spine more prominent at the C6-C7 than the C5-C6 disc levels. There was a mild degree of spinal canal stenosis at each of these levels with bilateral C7 and left C6 mild neural foraminal stenosis also felt to be present.

The employee was taken to surgery on 04/14/03, and at that time an anterior cervical discectomy and fusion was performed at C5-C6 and C6-C7 with an anterior plate placed at C5, C6, and C7.

The employee was seen in follow-up by Dr. Kesterson on 07/18/03, and at that time, he reported that on physical examination the employee's power was good. He did have some pain in the left trapezius. AP and lateral views of the cervical spine showed good placement of the pedicle screws and grafts at C5-C6 and C6-C7. Dr. Kesterson indicated that the employee had received physical therapy without significant improvement. He further noted that the employee was recently hospitalized for a myocardial infarction and had a coronary stent placed.

The employee was referred to Dr. Patrick Donovan, a physiatrist, on 08/25/03. Dr. Donovan examined the employee and found that he was postoperative chronic myofascial pain syndrome

with associated tension type headaches. Dr. Donovan recommended a series of localized trigger point injections.

The trigger point injections were performed on 09/02/03 and 10/21/03.

The employee was later referred for electrodiagnostic studies on 12/04/03. The study revealed evidence of a right carpal tunnel syndrome, which was neuropraxic in nature. There was no evidence of a cervical radiculopathy, myopathy, or brachioplexopathy.

The employee was seen in follow-up by Dr. Donovan, who reported that the employee had no significant improvement with injections.

The employee was referred for a repeat MRI of the cervical spine on 01/17/04, which reported no central canal stenosis, cervical cord enhancement, or enlargement. Facet ridging attenuates the distal left C6 and right C7 neural foramen.

The employee was seen by Dr. Jacob Rosenstein on 04/07/04. The employee reported progressively worsening pain. Upon physical examination, the employee was reported to be tender to palpation over the right occipital nerve and was tender to palpation over the right trapezius with some trigger points. Range of motion of the cervical spine was reduced. The motor examination revealed 5/5 strength in all upper extremity muscle groups. Sensory examination revealed hypesthesia to pin prick in the left hand. Reflexes were 1+ and symmetric. Radiographs indicated a cervical fusion at C5-C6 and C6-C7 with a plate. There was spondylosis noted at C4-C5. Dr. Rosenstein indicated that the employee's condition was getting worse. Dr. Rosenstein prescribed oral medications and recommended a right greater occipital nerve block, as well as trapezial trigger point injections.

The employee was referred for a cervical myelogram on 05/10/04, which indicated metal and bony C5-C6-C7 interbody fusion in anatomic position. The graft at C6-C7 had deteriorated and motion persisted at the C6-C7 segment. There was no motion at C5-C6. The employee underwent a bilateral occipital nerve block on 04/27/04 and trigger point injections on 04/27/04.

The employee was referred for electrodiagnostic studies on 06/17/04, which was reported to be abnormal and suggestive of a bilateral C6 radiculopathy. The employee was offered surgical intervention for the documented pseudoarthrosis.

The employee was taken to surgery on 07/09/04, and Dr. Rosenstein performed a revision procedure.

Postoperatively, the employee continued to experience pain, and the records reflect that he underwent cervical epidural steroid injections on 04/15/05 and 04/26/05.

The employee was eventually placed at Maximum Medical Improvement (MMI) by Dr. Rosenstein on 01/19/05. At that time, Dr. Rosenstein felt the employee had a 25% whole person impairment. The employee was later referred for chronic pain management.

The records indicate that the employee continued to receive symptomatic treatment, which included trigger point injections and occipital nerve blocks with no significant improvement.

The employee was referred for a cervical myelogram on 01/18/06, which indicated postsurgical changes including an anterior plate and screw fixation at C5-C6-C7 with interbody bone grafts, bilateral posterolateral rod and pars screw fixations at C5-C6-C7, and partial resection of the tips of the spinous processes at C5 and C6. There was no evidence of metal fatigue or loosening. The interbody grafts were potentially confluent. There was no ventral defect or stenosis at the levels of fixation. The facet joints at C5-C6 and C6-C7 were markedly narrowed and potentially confluent. Above the fusion at C4-C5, there were large anterior osteophytes. A 1 mm broad-based combined disc protrusion with spondylosis was present at C4-C5 producing a minimal ventral dural deformity and no stenosis or lateralization. This study found no filling abnormalities or stenosis at any of these levels.

The employee continued to receive symptomatic care from Dr. Rosenstein.

The employee was later referred for a cervical discogram on 06/06/06. This study reported that while both discs had direct posterior fissures with leakage, only the C4-C5 injection produced severe pain, which was partially concordant in that it was limited to the left and matched only the anatomically lower part of the range of the employee's pain.

The employee was seen in follow-up on 06/12/06 by Dr. Rosenstein, who suggested additional surgical intervention.

Disputed Services:

Items in Dispute: Anterior cervical discectomy with fusion at C4-C6 with plate removal at C5-C6 and C6-C7.

Decision:

Denial upheld.

Rationale/Basis for Decision:

The imaging studies indicate the employee had a small disc protrusion above the level of the previous fusion. A CT myelography indicated the central canal and neural foramen were patent. Cervical discography was not conclusive for discogenic pain. The available medical records do not support the medical necessity for fusion. Both the ***Official Disability Guidelines*** and ***ACOEM Guidelines*** recommend against fusion in the absence of instability. It is instead recommended to perform decompression. Current recommendations published in the journal ***Spine*** note that in cases of progressive neurologic deterioration or in the presence of mild to moderate myelopathy and concordant radiographic abnormality, the neural elements should be decompressed. Decompression may be accompanied by appropriate fusion, instrumentation, or both when instability or spondylolisthesis is documented radiographically.

References:

1. The ***American College of Occupational and Environmental Medicine Guidelines***. Accessed: 09/12/06.
2. The ***Official Disability Guidelines***, 11th Edition, The Work Loss Data Institute. Accessed: 09/12/06.
3. Nicholas C. Bambakidis, M.D., Iman Feiz-Erdan, M.D., Jeffrey D. Klopfenstein, M.D., and Rolder K. H. Sonntag, M.D., ***Indications for Surgical Fusion of the Cervical and Lumbar Motion Segment***. ***Spine*** 2005; 30-S2-S6.

The rationale for the opinion stated in this report is based on the above mentioned references, record review, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

YOUR RIGHT TO REQUEST A HEARING

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 thirty (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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
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 this dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the injured worker via facsimile or U.S. Postal Service this 13th day of September, 2006 from the office of IMED, Inc.

Sincerely,

Charles Brawner
Secretary/General Counsel