IMED, INC.

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NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE:
IRO TRACKING NUMBER: M2-06-1892-01
NAME OF REQUESTOR: Steven Enabnit, D.C.
NAME OF CARRIER: TASB Risk Management Fund
DATE OF REPORT: 09/17/06
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 a chiropractic physician reviewer who is Board Certified in the area of Chiropractic Medicine 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. Cervical MRI dated 01/30/02.
2. Lumbar MRI dated 04/18/02.
3. Chiropractic office notes from Accident & Injury Chiropractic Center dated 07/26/02 thru 07/13/06.
4. Functional Capacity Evaluation dated 07/29/02.
5. NCV and/or evoked potential study of the lower extremity dated 08/22/02, and of the upper extremity dated 09/23/02.
6. J. Ghadially, M.D., notes from 10/15/02 thru 04/12/05.
7. P. Michaelson, M.D., Independent Medical Evaluation dated 10/16/02.
8. Functional Capacity Evaluation dated 10/17/02.
9. Cervical spine x-ray dated 12/04/02.
10. Cervical spine epidural steroid injection from 12/04/02 thru 12/30/02 times three.
11. Functional Capacity Evaluation dated 01/07/03.
12. Lumbar MRI dated 12/04/04.
13. Cervical MRI dated 04/12/05.
14. P. Jennings, M.D., notes dated 04/22/05.
15. R. Francis, M.D., noted dated 07/05/05.
16. Peer reviews dated 06/29/06.
17. IRO dated 07/10/06.

Clinical History Summarized:

The employee was originally injured on ___ when he was approximately 32 years of age. According to a report generated by Accident & Injury Centers, S. Enadnit, D.C., the employee was injured "as a result of running to a co-worker and bending over real fast to hold a wrench up so it would not fall on the co-worker". This resulted in a sprain/strain injury to the lumbar spine. The employee was also being treated for an injury to the cervical spine as well.

An initial cervical spine MRI performed in January, 2002 revealed normal soft tissues, fascial planes, and neurovascular bundles. The paravertebral tissues were also within normal limits, but there was a mild annular bulge at C5-C6.

On 04/18/02, a lumbar spine MRI revealed a normal conus medullaris with no osseous central or foraminal stenosis. However, there was some moderate bilateral degenerative joint disease and facet arthropathy at L5-S1 with no evidence of acute or traumatic structural pathology

A Functional Capacity Evaluation (FCE) of 07/29/02 confirmed a severely morbidly obese individual with a height of 5 foot 7 inches and a weight of 275 pounds.

Pain levels of July, 2002 were listed as 6/10 in the cervical spine and 6/10 in the lumbar spine.

A review of records suggests that serial range of motion studies were performed in July, 2002 and August, 2002 with regard to the cervical and lumbar spine regions. In the cervical spine region, there was a decrease in range of motion between July, 2002 and August, 2002. However, in the lumbar spine region, flexion of the lumbar spine became normal while extension worsened.

Despite the lack of significant improvement between December, 2001 through August, 2002, the employee did continue with conservative chiropractic management. Treatment as of 08/30/02 consisted of conservative chiropractic management three times a week. By 11/22/02, the employee still reported low back pain at 6/10, and in addition, his neck pain was also rated 6/10. However, curiously the employee reported a decrease in pain levels down to 4/10 in the lumbar spine after treatment. However, this did not result in any significant long-term benefit since his pain levels as of 11/25/02 were again listed as 6/10.

During the interim while the employee was receiving chiropractic care, she underwent a lower extremity nerve conduction velocity study on 08/22/02. The only significant finding was that of a tibial H reflex which was within normal limits. An EMG was not performed, but a lower extremity evoked potential was performed documenting a suggested dermatomal evoked potential evidence of left L3, L5, and S1 radiculopathy. However, it should be noted that the ***Fourth Edition*** of the ***AMA Guides to the Evaluation of Permanent Impairment*** does not recognize evoked potentials as documenting radiculopathy. Only an H-wave reflex and/or full EMG can document radiculopathy according to the ***AMA Guides, Fourth Edition***.

Work conditioning was started sometime around 11/27/02 and lasted through at least 12/23/02. The employee then began monthly follow-up visits during the early part of 2003 with an interim examination being performed on 07/11/03. On this date, the employee's pain level was reported as 6/10 in the neck and 6/10 in the lumbar spine. The cervical examination suggested a plethora of positive orthopedic testing findings. Kemp's, Lasegue's, Braggard's, Valsalva, and Yeoman's tests were considered positive. Testing in the cervical spine did not reveal any significant abnormalities. Nevertheless, the employee's range of motion was significantly reduced in all planes in the cervical and lumbar spine, and in fact, the motions in July, 2003 were significantly worse than they were in July, 2002 during the initial FCE which reported range of motion findings.

Treatment continued throughout 2004, 2005, and 2006. The most recent chiropractic notes was dated 06/21/06. On this date, pain levels were now listed as 6/10 in the neck and 7/10 in the lumbar spine.

On 09/23/02, an additional upper extremity nerve conduction velocity and evoked potential was performed. The nerve conduction study did reveal a moderate and bilaterally symmetric reduction in sensory nerve conduction velocity of the median nerve at the wrist. The wrist finding would be considered incidental since the employee did not have any significant positive orthopedic tests or significant occupational injury which could result in wrist injuries. Nevertheless, the evoked potential also suggested evidence of cervical radiculopathy slightly more pronounced on the left. There was also evidence of bilateral sensory neuropathy at the median nerves of the wrist, which the evaluator suggested was consistent with carpal tunnel syndrome.

Back in October, 2002, the claimant had been referred to J. Ghadially, M.D., for an orthopedic evaluation. Dr. Ghadially suggested the need for facet blocks and a facet arthrogram, as well as ongoing aggressive exercise and a pain management program. Pharmaceutical treatments included Motrin and Trazodone.

Repeat evaluations by Dr. Ghadially were performed in November, 2002. epidural injections and facet blocks were suggested in the cervical and/or lumbar spine respectively. A myelogram of the cervical spine was also suggested.

Repeat radiographs were performed on 12/04/02. At that time, there was no acute compression fracture of the cervical spine, but there was mild spondylosis noted from C3-C4 through C5-C6 with small posterior osteophytes. Also on that date, the claimant underwent an epidurogram of the cervical spine followed by an intra-epidural injection with contrast. There was apparent mild to moderate pain relief slightly more on the left. This was considered to be a successful first series of cervical epidural steroid injection. Two additional cervical spine injections were performed on 12/18/02 and 12/30/02.

Dr. Ghadially continued treating the employee through 2003. On 02/21/03, the employee had gained weight and now weighed 285 pounds still on a 5 foot 7 inch frame. It was now suggested that he had an internal disc disruption of L5-S1, along with a disc herniation at C5-C6. Neither of these new diagnoses were ever documented on MRI studies. Nevertheless, Dr. Ghadially suggested the need to undergo a discogram of the cervical spine and continued medications. This was to include Trazodone, Motrin, Flexeril, and Vicodin.

A myelogram of the lumbar spine was performed on 04/12/04. At T12-L1, there was no herniation, at L1-L2 there was no herniation, at L2-L3 there was no herniation. A subtle 3 mm right posterolateral protrusion was noted at L3-L4. At L4-L5, there was a 4 mm posterocentral protrusion. At L5-S1, there was a pars defect noted at L5, along with a 3 mm broad-based posterior protrusion. There was some underfilling of the nerve roots of L5-S1 bilaterally.

A repeat examination by Dr. Ghadially on 05/28/04 recommended ongoing pharmaceutical management.

A cervical spine myelogram was performed on 04/12/05. At this point, a C3-C4 broad-based protrusion was noted, along with a C4-C5 3 mm broad-based protrusion and a C5-C6 3 mm broad-based protrusion.

Dr. P. Jennings performed an evaluation on 04/22/05. This physician had a physician assistant evaluate the employee, and it was the opinion of the physician assistant that the employee had failed all conservative measures and was to proceed with surgical intervention if the employee agreed. Apparently he did not agree, but nevertheless, he was referred to a second opinion, R. Francis, M.D., who also suggested that surgical intervention was needed at L5-S1.

By October, 2005, Dr. Francis was still recommending surgical intervention at L5-S1. As of 05/15/06, S. Enabnit, D.C., suggested that the employee's condition was "unchanged". Pain levels were still rated at 6/10 in the neck and 7/10 in the low back. By 05/23/06, a note provided by Dr. Francis suggested that the claimant had not yet undergone surgical intervention, but it was due to "a family problem". Dr. Francis was still recommending surgical intervention.

As of 06/21/06, Dr. Enabit wrote an office note suggesting that the claimant did not want to attempt surgical intervention. He was refusing surgery, and therefore, Dr. Enabit was recommending a form of vertebral axial decompression. This was originally denied, and then on 06/22/06, Dr. Enabit submitted a reconsideration request citing one recent study documented in the ***New England Journal of Medicine*** suggesting that he was justified in attempting axial decompression maneuvers. As of 07/13/06, Dr. Enabit again submitted another reconsideration request, and this was accompanied by additional opinions in which he had won an IRO citing individual research documentation.

Disputed Services:

Items in Dispute: Preauthorization denied for 15-20 sessions of spinal decompression therapy.

Decision:

The preauthorization denial for 15-20 sessions of spinal decompression therapy is upheld.

Rationale/Basis for Decision:

This employee has been treated for a sprain/strain injury since approximately ___ with absolutely no change in objective or subjective findings. The employee was morbidly obese

when he first sustained this alleged occupational injury, and the initial results of the diagnostic tests failed to reveal any acute or traumatic structural pathology. Regardless, at this point, the employee has been recommended to undergo vertebral axial decompression. While Dr. Enabit did document one individual research paper to support his opinion, there are several dissenting opinions with regard to the use of vertebral axial decompression and/or other forms of traction. Most consensus guidelines including the ***Official Disability Guidelines*** and/or the ***American College of Occupational & Environmental Guidelines*** indicate that vertebral axial decompression is not recommended. "While there are some limited promising studies, the evidence in support of vertebral axial decompression is insufficient to support its use in low back injuries." "Although the American Medical Association, FDA, and Centers for Medicare and Medicaid services all consider decompression therapy to be a form of traction, the manufacturer of these devices consider them different from traction. The evidence suggests that any form of traction is probably not effective." Since the ***Official Disability Guidelines*** as well as the ***American College of Occupational & Environmental Guidelines*** are a consensus guideline, these take into consideration all of the research available, not just individual research articles that support the use of or refute the use of vertebral axial decompression. These guidelines utilized for this opinion are upgraded as recently as 09/08/06.

The rationale for the opinion stated in this report is based on the 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 19th day of September, 2006 from the office of IMED, Inc.

Sincerely,

Charles Brawner

Charles Brawner
Secretary/General Counsel