



Medical Review Institute of America, Inc.
America's External Review Network

SENT TO:

Texas Department of Insurance
Health & Workers' Compensation Network Certification and QA
Division (HWCN) MC 103-5A
Via E-mail IRODecisions@tdi.state.tx.us

Injured Employee

Requestor:

Respondent:

UNITED STATES FIDELITY & GUARA C/O F.O.L.
CONTACT: KATIE FOSTER
FAX: (512) 867-1733
PHONE: (512) 435-2266

DATE: January 25, 2007

RE: IRO Case #:M2-07-0492-01

Name: ---

Coverage Type: Workers' Compensation Health Care (Non-network)

Type of Review: Prospective

Medical Review Institute has been certified, certification number 5278, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to the IRO for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

The IRO has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, the IRO reviewed the medical records and documentation provided to the IRO by involved parties.

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This case was reviewed by a Pain Management specialist. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of Medical Review Institute of America I certify that:

1. There is no known conflict between the reviewer, the IRO and/or any officer/ employee of the IRO with any person or entity that is a party to the dispute, and
2. A copy of this IRO decision was sent to all of the parties via U.S. Postal Service or otherwise transmitted in the manner indicated above on 1/29/07.

Right to Appeal

You have the right to appeal the decision by seeking judicial review. The decision of the IRO is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery the appeal must be filed:

1. Directly with a district court in Travis County (see Labor Code §413.031(m), and
2. Within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for a CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Case Analyst: Valerie O ext 554

Case Fulfillment Specialist

DATE OF REVIEW: JANUARY 29, 2007

IRO Case #: M2-07-0492-01

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Questions for Review:

ITEM(S) IN DISPUTE: Repeat bone scan and repeat CT scan L3–S1 joint.

A description of the qualifications for each physician or other health care provider who reviewed the decision:

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.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

Provide a Description of the Review Outcome that Clearly States Whether or Not Medical Necessity Exists for Each of the Health Care Services in Dispute:

The item in dispute, repeat bone scan and repeat CT scan L3–S1 joint, is not medically necessary.

Information provided to the IRO for review**Records from the State:**

Notification of IRO Assignment, 12/8/06

Notice of Receipt of Request for Medical Dispute Resolution, 12/8/06

Medical Dispute Resolution Request/Response form, 2 copies

Table of Disputed Services

List of Providers

Letter from Karen Hadley, 11/1/06

Letter from Cynthia Sailors, 11/8/06

Letter from the patient, handwritten, undated

Records from the Provider:

Patient notes, Shannon Clinic, 3/18/03, 4/15/03, 4/16/03, 6/3/03, 3/5/04, 3/29/04, 5/28/04, 8/20/04, 10/29/04, 1/14/05, 1/24/05, 3/1/05, 6/10/05, 7/5/05, 8/10/05, 11/8/05, 2/7/06, 3/21/06, 6/16/06, 9/6/06, 10/14/06

Discharge Summary, Shannon West Texas Memorial Hospital, 7/1/05

Operative reports, 6/30/05

Radiology reports, 6/30/05, 8/11/05, 9/19/05, 11/4/05, 2/6/06, 6/14/06, 9/21/06,

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Records from the Insurance Company:

Patient notes and lab reports, West Texas Medical Associates, 1/11/02, 2/12/02, 4/10/02, 4/24/02, 6/4/02, 6/11/02, 6/12/02, 6/14/02, 6/17/02, 6/19/02, 6/20/02, 6/24/02, 6/26/02, 6/27/02, 7/2/02, 7/17/02, 7/22/02, 7/25/02, 8/20/02, 8/28/02, 9/18/02, 10/23/02, 12/11/02, Patient notes, William Pollan, DO, 2/6/02, 2/11/03, 4/15/03
Electrodiagnostic test reports, 1/16/04, 1/16/04
Patient notes, Duncan Fischer, MD, PhD, 2/28/02
Radiology reports, 4/19/02, 5/3/02, 7/10/02, 3/28/03, 10/8/03, 10/29/03, 8/11/05, 9/19/05, 9/19/05, 11/4/05, 2/6/06, 6/14/06
MediCenter Nursing Assessment, 7/29/02
EDP History & Physical Worksheets, 7/29/02, 7/30/02
Operative report, 2/26/03
Letters from Farrukh Hamid, MD, Intracorp, 3/19/03, 5/20/03
Letter and Independent Medical Evaluation, W. Gordy Day, MD, 9/26/03
Admission records, 9/25/03
SOAP notes, Brian Anderson DC, 1/16/04 – 1/26/04
Statement of Medical Necessity, 1/28/04
Designated Doctor Examinations, Rodney Simonson, MD, 2/9/04, 8/11/04, 6/13/05
Report of Medical Evaluation, 2/9/04, 8/11/04, 6/13/05
Progress notes W. Gordy Day, MD, 2/10/04, 2/24/04, 3/5/04, 3/30/04, 4/29/04, 6/24/04, 3/7/05, 8/4/05, 1/20/06, 2/3/06, 4/7/06, 5/9/06, 7/14/06, 8/23/06
Industrial Rehabilitation Initial Evaluation, 2/25/04
Patient notes, Luis Duarte, MD, 3/5/04, 5/28/04, 8/20/04, 1/14/05, 3/1/05, 6/10/05, 11/8/05, 2/7/06, 3/21/06, 6/16/06, 9/9/06, 10/14/06
Neurosurgery–Procedure Order and Pre–Certification for, 3/5/04
Operative report, Lumbar myelogram and CT lumbar spine, 3/29/04
West Texas Rehab Center, Industrial Rehab Daily Notes and Activity Flow Sheets, 2/27/04 – 4/28/04; 8/18/05 – 9/28/05
Neurosurgery Progress Sheet, 10/29/04
Operative report, lumbar discography and CT scan, 1/24/05
Hospital records, Shannon Medical Center, 1/24/05
Functional Capacity Evaluation, 2/22/05
Letter, W. Gordy Day, MD, 4/28/05
Discharge Summary, Luis Duarte, MD, 7/1/05
Operative reports, Admission H&P, 6/30/05
Hospital records, Shannon Medical Center, 6/30/05 – 7/1/05
Patient records, Emmette Flynn, MD, 6/30/05
Admission history and physical, 7/4/05

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Hospital records, Shannon Medical Center, 7/4/05 – 7/5/05
West Texas Rehabilitation Center, Back/Neck Evaluation, 8/17/05
West Texas Rehab Therapy Progress Report/Plan of Care, 9/12/05
Letter from William Abraham, MD, 10/13/05
Therapy Solutions, PT Plan of Care/Initial Evaluation, 9/29/05
Therapy Solutions, PT Progress/Treatment notes, 10/3/05 – 12/9/05
Report of Medical Evaluation, 1/20/06, 3/23/06
Disability Determination, Robert Lawson, MD, 3/26/06
Functional Abilities Evaluation, 3/23/06
Retrospective Peer Review, 5/4/06
Electrodiagnostic study report, 8/16/06
MRI report, lumbar spine, 9/21/06

Patient Clinical History [Summary]:

The patient is a 60 year-old male who is reported to have injured his low back on _____. The patient initially was evaluated at a local emergency room and later came under the care of Dr. Pollen. The patient received extensive conservative care and was later referred to Dr. Luis Duarte. The patient underwent a thorough diagnostic evaluation and was subsequently found to have degenerative disc disease at two levels at L3–4 and L4–5. The patient subsequently underwent lumbar discography, which indicated concordant pain at both of these levels. Dr. Duarte recommended that the patient undergo an interbody fusion at L3–4 and an artificial disc replacement at L4–5.

The patient was subsequently taken to surgery on 6/30/05. At this time Dr. Duarte performed an anterior lumbar interbody fusion at L3–4 and a Charite total disc replacement at L4–5.

Postoperatively the patient was reported to have had a significant improvement in his low back pain. X-rays performed on 8/11/05 indicate postoperative changes secondary to PLIF at the L3–4 disc space, and a prosthetic disc is present at L4–5. The patient was seen in follow up and reported to have continued to improve. Of note, when examined on 08/10/05 the patient's lower extremity reflexes were depressed.

Serial radiographs indicate no hardware complications, no lucency is reported, and there has been no reported migration of the artificial disc. The patient began to report increasing symptoms, and on 2/7/06 the patient rates his pain as a 5 on a 10-point scale. The patient reports problems with nocturnal spasms, reports the onset of sexual dysfunction, and indicates he is going to apply for disability. On examination the patient has a normal gait. He has good strength in both lower extremities. He has 2+ and symmetric knee jerk and ankle jerk reflexes. Strength testing reveals no weakness. The patient has normal sensation in both lower extremities.

The patient is subsequently diagnosed with post laminectomy syndrome. On 6/16/06 the patient was seen in follow up, and at this time he reports low back pain with radiation into the left lower extremity. He reports numbness and tingling into the foot on the left side. On physical examination the patient is reported to have 4.5 to 5- weakness in the tibialis anterior on the left side. Straight leg test is reported to be positive. There is atrophy in the calf on the left side. As a result, Dr. Duarte diagnosed the patient with an L5 radiculopathy in the left lower extremity. Dr. Duarte reports that the patient was seen by Dr. Lawson who reported the patient's right calf size is 26 cm, and the left calf is 24 cm, reporting a 2 cm difference. Dr. Duarte opines this atrophy is secondary to chronic radiculopathy. Dr. Lawson's report indicates the patient's calf measurements were 39 cm and symmetric. The patient's ankles were measured at 26 cm on the right and 24 cm on the left.

The patient was referred for electrodiagnostic studies on 08/16/06. This study is suggestive of a left S1 nerve root irritation. I would note that the needle study reports polyphasic waves in the left medial gastrocnemius; however, testing of the paraspinal musculature shows normal insertional activity with no evidence of fibrillation or polyphasic waves.

The patient was subsequently referred for an MRI of the lumbar spine. This study performed on 09/21/06 finds the L1-2, L2-3, and L3-4 disc spaces unremarkable. At L3-4 the interbody spacer is seated within the intervertebral space. At L4-5 the disc and thecal sac are grossly maintained. The neural foramina appear patent, and there is minimal facet arthrosis at L4-5. At L5-S1 the disc, thecal sac and neural foramina are maintained. There is minimal bilateral facet arthrosis. The patient is reported to have post surgical changes as described above with no focal disc extrusions or central canal stenosis demonstrated. There is no significant neural foraminal narrowing or stenosis noted.

The patient was seen in follow up on 10/14/06. At this time the patient reports his pain is 7/10. On physical examination the patient's gait is normal. He is Romberg negative. There is no weakness in the upper or lower extremities. Tone is normal. There is no ankle clonus, and reflexes are reported to be depressed. Sensory examination is intact to light touch. Straight leg raising is reported to be mildly positive. Faber's maneuver is reported to be positive, and there are painful sacroiliac joints bilaterally. Dr. Duarte notes that the MRI of the lumbar spine fails to reveal any evidence of degeneration at the L5-S1 disc or the disc above the fusion. The screws appear to be in good position. There is no loosening of the hardware, and the fusion appears to be progressing nicely. As a result, the patient is diagnosed with post lumbar laminectomy syndrome, low back pain and bilateral hip pain. Dr. Duarte recommends that the patient undergo a bone scan and a CT scan of the lumbar spine including the sacroiliac joints.

Analysis and Explanation of the Decision – Include Clinical Basis, Findings and Conclusions Used to Support the Decision:

The repeat bone scan and repeat CT scan of the lumbar spine to include the sacroiliac joints is not medically necessary. The available records indicate the patient is stable. Serial imaging studies have not suggested a failure or migration of hardware. A recent MRI reports only mild evidence of stenosis. A bone scan would be an appropriate consideration to evaluate this patient for active disease. The patient has recently undergone an MRI, which evaluated the soft tissues and found no evidence of a neural compressive lesion. The available records do not suggest the patient requires revision or that Dr. Duarte is considering additional operative intervention. The patient's previous imaging studies have not suggested the presence of an abnormality that would be more effectively evaluated by CT myelography.

de Vlam reports "The data suggest that the HIG-scan is not useful in detecting inflammatory spinal lesions in ankylosing spondylitis. Littenberg found "There is weak evidence that SPECT is useful in: (a) detecting pseudarthrosis after failed spinal fusion, (b) evaluating young patients with back pain and (c) distinguishing benign from malignant lesions in cancer patients. SPECT has not been sufficiently studied in any other setting. We found no reports on the clinical outcome of SPECT or its cost-effectiveness. The decision to use SPECT in most patients with low back pain cannot be supported by clinical trials. Its effect on clinical management and cost-effectiveness are unknown". The American College of Radiology reports "The role of the isotope bone scan in patients with acute low back pain has changed in recent years with the wide availability of magnetic resonance imaging and especially contrast-enhanced magnetic resonance imaging. The bone scan is a moderately sensitive test for detecting the presence of tumor, infection, or occult fractures of the vertebrae but not for specifying the diagnosis. The yield is very low in the presence of normal plain x-rays and laboratory studies, and highest in known malignancy. The test is contraindicated in pregnancy. High-resolution isotope imaging including single-photon emission computed tomography may localize the source of pain in patients with articular facet osteoarthritis prior to therapeutic facet injection. Similar scans may be helpful in detecting and localizing the site of painful pseudoarthrosis in patients following lumbar spinal fusion. Plain and contrast-enhanced magnetic resonance imaging has the ability to demonstrate inflammatory, neoplastic, and most traumatic lesions as well as show anatomic detail not available on isotope studies. Gadolinium-enhanced magnetic resonance imaging reliably shows the presence and extent of spinal infection, and is useful in assessing therapy. Magnetic resonance imaging has therefore taken over the role of the isotope scan in many cases where the location of the lesion is known. The isotope scan remains invaluable when a survey of the entire skeleton is indicated".

The Official Disability Guidelines report "CT Myelography is appropriate if MRI is unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. (Slebus, 1988) (Bigos, 1999) (ACR,

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2000) (Airaksinen, 2006) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Invasive evaluation by means of myelography and computed tomography myelography may be supplemental when visualization of neural structures is required for surgical planning or other specific problem solving. (Seidenwurm, 2000)".

A Description and the Source of the Screening Criteria or Other Clinical Basis Used to Make the Decision:

1. de Vlam K, Van de Wiele C, Mielants H, Dierckx RA, Veys EM. Is ^{99m}Tc human immunoglobulin G scintigraphy (HIG-scan) useful for the detection of spinal inflammation in ankylosing spondylitis? *Clin Exp Rheumatol*. 2000 May-Jun;18(3): 379-82.
2. Littenberg B, Siegel A, Tosteson AN, Mead T, Clinical efficacy of SPECT bone imaging for low back pain, *J Nucl Med* 1995 Sep;36(9): 1707-13
3. Anderson RE, Drayer BP, Braffman B, Davis PC, Deck MD, Hasso AN, Johnson BA, Masaryk T, Pomeranz SJ, Seidenwurm D, Tanenbaum L, Masdeu JC. Acute low back pain--radiculopathy. American College of Radiology. ACR Appropriateness Criteria. *Radiology* 2000 Jun;215(Suppl): 479-85. [15 references]
4. The Official Disability Guidelines, 11th edition, The Work Loss Data Institute. Accessed: 01/24/2007.