

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0241-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician:	Dr. L, MD
(Treating or Requesting)	

December 6, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedics. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Medical Director

CLINICAL HISTORY

___ originally consulted with Dr. L on 11/6/03. He was noted to be thirty-seven years old at the time he was injured while working on ___. He was apparently lifting some lumber and slipped and fell and developed, initially, some left arm pain and lower back pain radiating into his hips and legs, worse on the left side. He was said to have had no history of previous back problems and had been receiving chiropractic treatments. He also apparently had a lumbar steroid injection, which did not help him. He was wearing a back brace and taking medications. The pain was described as lumbosacral in origin, radiating into the left hip and buttock and down the lateral aspect of the left leg. He was said to have had an MRI scan showing disc bulging at L3-4 and L4-5. Electrophysiological studies were said to be negative. He was noted to be a smoker who did not drink. He never had had any surgery. Exam showed he was 5'8" and weighed 203 pounds. He had diminished lumbar mobility with tenderness over the left S1 area and positive straight leg raising on the right at 60 degrees and on the left at 30-45 degrees. His deep tendon reflexes were symmetrical and he had some minimal hypoalgesia on the lateral aspect of his leg. He had no obvious muscular weakness and no pathological reflexes. The impression was chronic lumbosacral strain with left leg pain, possibly radiculopathy.

On 8/10/03 an MRI report indicates that the L2-3 level is normal. At L3-4 there is a very mild broad-based disc bulge with effacement on the thecal sac and thickening of the ligamentum flavum. At L4-5 there was a mild broad-based disc bulge with no deformity of the thecal sac and patent neural foramina. At L5-S1 there was no significant disc bulging, no evidence of canal stenosis, and patent neural foramina. The impression was mild disc bulges at L3-4 and L4-5.

On 12/4/03 Dr. L saw the patient again, indicating that MRI had shown a disc protrusion at L3-4 and L4-5, which is not what was reported on the original MRI. He was having mechanical back pain and also some radicular leg pain. Dr. L suggested a myelogram and CT scan and continued his medications.

On 1/9/04 there is a report of a CT done post-myelogram. At L2-3 and L3-4 levels there were no significant abnormalities. At L4-5 there was mild disc bulging with mild encroachment on the anterior aspect of the thecal sac and inferior recesses of the neural foramina. There was noted to be congenital narrowing of the spinal canal and some thickening of the ligamentum flavum causing mild to moderate spinal canal stenosis. At L5-S1 there was congenital narrowing of the canal with mild diffuse disc bulging causing mild encroachment on the thecal sac. The neural foramina were maintained. The facet joints were normal. There was noted to be mild to moderate spinal canal stenosis at that level. Myelogram confirmed the above findings, showing narrowing at the thecal sac from L4 to S1 with no major central or lateralizing defects.

On 1/20/04 Dr. L saw the patient again, noting that he was having continued back and leg pain. He noted that he had congenital spinal stenosis, but did have some degenerative changes. He was taking medications. He recommended continuation of conservative care. On 3/1/04 Dr. L saw the patient with continued lower back and leg pains. He apparently had been seen by Dr. F who felt he could return to light duty, but the patient stated he was unable. He had a positive straight leg raising at 45 degrees bilaterally. Surgery was felt to be a possibility.

On 3/29/04 Dr. L saw the patient, noting he was unable to work because of his severe mechanical back pain and hip and leg pain. He said he has multi-level disc disease and stenosis with root compression. Straight leg raising was positive. He was noted to walk with a flexed posture in the low back. He recommended lumbar discography. On 4/12/04 he was seen with similar complaints and again discography was recommended. On 4/29/04 he was noted to be getting worse with back and leg pain. He had not improved with conservative care. The recommendation was to proceed with lumbar discography. Exam was unchanged. On 5/6/04 Dr. L noted he had continued pain and he again recommended discography. On 7/13/04 Dr. L noted he was having continued lumbosacral pain and bilateral hip and leg pain. He had been approved for discography. He recommended that the discography be performed.

On 7/29/04 he was seen again post discography. This study was said to be very positive at L5-S1 and relatively normal at L4-5. Treatment

options were discussed. These would be conservative therapy or surgery.

On 8/29/04 Dr. L saw the patient, noting that he was having increasingly severe mechanical low back pain, bilateral hip and leg pain. The patient apparently wished to proceed with surgery and Dr. L suggested L4 through S1 decompression, fusion, and instrumentation.

On 7/20/04 a discography report indicates mild extravasation of contrast material noted at L3-4 with mild to moderate disc bulging with mild encroachment on the thecal sac causing mild spinal stenosis. At L4-5 there was extravasation of contrast material posterolaterally with moderate diffuse bulging causing mild to moderate spinal canal stenosis. At L5-S1 there was minimal extravasation of contrast material posterolaterally to the right. There was no dural sac or neural foraminal compression.

There is an operative report regarding the discogram on 7/20/04 indicating that the patient experienced significant pain on injection of L5-S1 causing back, bilateral hip and leg pain.

On 9/13/04 Dr. L corresponded with Dr. S, DC, noting he had mechanical back pain exacerbated by walking and standing with pain radiating into his hip and leg areas. He was noted to walk with a flexed posture. He again recommended surgery. On 9/27/04 he was the patient again, noting that surgery had apparently not been authorized or approved. He stated the patient reports that he did not smoke, which was one of the reasons his surgery had been denied. He was walking with a flexed posture and had limited mobility of the back with positive straight leg raising. He recommended following the patient.

REQUESTED SERVICE(S)

Medical necessity of proposed lumbar laminectomy w/fusion and instrumentation L4-S1 w/in-patient stay x1 day and TLSO back brace.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The proposed surgery is apparently being recommended to treat the diagnosis of spinal stenosis, which is felt to be present at L4-5 and L5-S1 level. It is widely accepted that only patient with strong

concordant preoperative physical and imaging findings are reasonable candidates for lower back surgery. The medical records do not reflect that this individual has any focal neurological findings such as reflex changes, motor weakness, or discreet dermatomal sensory loss. He does demonstrate positive straight leg raising, which may be a result of his limited lumbar mobility.

The Clinical Practice Guidelines, #14, published by the U.S. Department of Health and Human Services notes under their section on surgery for spinal stenosis that surgical decisions for patient with spinal stenosis should not be based solely on imaging tests, but should also consider the degree of persistent neurogenic claudication symptoms, associated limitations and detectable neurological compromise. The report goes on to state that the primary symptoms of severe spinal stenosis are neurogenic claudication with leg pain on walking or standing, which is relieved by sitting in a flexed position of the spine. The patient does appear to have complaints of leg pain; however, there is no clear-cut indication in the medical records suggesting that his pain is acutely relieved by flexing his spine in a sitting position. Therefore, there would be weak evidence to suggest that he is suffering from significant neurogenic claudication. Furthermore, the post discogram CT done on 7/20/04 shows that the dural sac and neural foramina are maintained at L5-S1 with no herniation or bulging of the disc noted and no evidence of any significant stenosis at that level. At L4-5 level there are some spondylitic changes and thickening of the ligamentum flavum causing mild to moderate spinal stenosis; therefore, the imaging studies would certainly not support any type of surgical intervention at L5-S1 level and would be questionably supportive of an L4-5 surgery. The indication for fusion is also felt to be unsupported, as the patient has no indication of spinal instability at either of the proposed levels for spinal fusion.

Articles published by Carragees from December 1999 to December 2000 demonstrated the unreliability of high intensity zones and of the concordance of pain responses for patients with symptoms of back pain for more than six months. This casts considerable doubt on the validity of using discography to identify the pain generator in the lower back. Therefore, basing surgery on a discogram, which produced pain at a level that on post-discogram CT showed no evidence of stenosis would be questionable.

Therefore, the preponderance of the evidence in this file would suggest that there is no conclusive evidence to support lumbar laminectomy, fusion, and instrumentation of the L4-5 and L5-S1 levels in this individual. IF the patient had had positive EMG and nerve conduction studies or other focal neurological findings, then decompression might be a reasonable alternative. In the absence of focal neurological deficits, which correspond exactly with his imaging findings, surgical intervention would be expected to have a low probability of success.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission 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. Postal

Service from the office of the IRO on this 7th day of December, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: