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April 21, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #:

IRO #:

M2-05-1057

5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed doctor board certified and specialized in orthopedics. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc 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 Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Letters of denial from Concentra

Kenneth Berliner, MD

Ramiro Torres, DC

John Sklar, MD

Stone, Loughlin & Swanson, attorneys at law

Dr Athari

Boris Payan, MD

Austin and Associates, Medical Litigation Support Services

Suzanne Page, MD EMG/NCV:

Alamed Khalifa, MD

Ajay Aggarwal, MD

Leonard Hershkowitz, MD

Walter Long, MD

Vista Medical Center Hospital

Thomas Cubberly, MD

East Side Imaging, Edward Knudson, MD MRI and Myelo/CT
Andrew McKay, MD
William Hicks, DC

CLINICAL HISTORY

Thomas Cubberly MD, RADDOC Medical Assoc MRI 5-12-04: facet changes 45 and 51, L5S1 slight bulging of disc posterolateral on the left side which is of questionable clinical significance due to its minimal extent. No herniation. **East Side Imaging, Edward Knudson, MD MRI 5-12-04:5-12-04:** “at L5S1 there is a left posterolateral disc protrusion of approx 3mm consistent with a disc herniation...” **Dr. Torres, DC, 6-3-04:** pt lifting air conditioner coil and felt LGP. Reported. Next day pain increased tremendously. PT. MRI showed a lumbar disc bulge per pt. 9/10 LBP, L buttock, and into left knee. Sitting tolerance of 40 minutes. PMH negative for WC. SLR -. Strength 4/5 secondary to guarding. Well leg raise + at 40 degrees. (high degree of specificity). Sensory decreased L5-S1 left. DTR’s OK. No imaging for review. Dx: lumbar disc syndrome, radiculitis, strain, dyskinesia. Rec’d: passive care, then independent protocol, i.e., active program. **Dr. Torres 6-11-04:** + SLR, decreased sensation left, 4/5 weakness, difficulty with heel to toe walk. EMG Dr Athari 7-1-04: nl EMG/NCV in legs, but a few + sharp waves L5S1 level bilaterally. Dx: “suggestive of L5-S1 nerve root irritation bilaterally.” **Dr. Torres 7-7-04:** pt c/o back pain 8/10 at worst, radiating left leg pain with numbness. PE decreased sensation L4 and L5, DTR’s OK, 4/5 strength left leg, + SLR. **Boris Payan, MD, 7-15-04:** LBP, radiating left leg to foot and to the right toe. Sitting. PE: 5/5 all groups, DTRs =. SLR + left at 30. Sx: lumbar strain, HNP L5-S1, lumbar radiculopathy. **Dr. Sklar, 7-26-04 UM:** initial MD visit no neuro deficits and SLR negative, c/o back and left hip pain. But by 6-3-04 pt c/o left leg pain, + SLR, well leg test, decreased sensation L5S1 left. Sklar wonders why the DC’s findings of + SLR, etc were not seen by others. This pt had a “lumbar strain... would reasonably have resolved within one to two months with or without treatment.” And gives a specific date for resolution of symptoms, 6-7-04! He sites The Official Disability Guidelines. Dr. Sklar denies any and all further treatment. (Dr. Sklar’s conclusions are startling! And worth reviewing). Austin and Associates, Medical Litigation Support Services, 7-27-04: records Dr. Sklar’s report. **Dr. Torres 8-2-04:** sciatica to the toes, numbness, decreased sensation L5S1, normal reflexes, MMT 5/5, +SLR on right, recs ESI. **Vista Medical Center Hospital: ESI. Dr. Payan. 8-10-04:Berliner 8-19-04:** repetitive lifting and bending on assembly line 4-11-04.. Treated with PT, ESI temp relief, NSAID, tramadol. Decreased Achilles reflex, SLR= left with radicular reproduction to toes. Decreased sensation left later foot and heel. Weak toe flexors and gastroc. MRI shows a “large disc herniation” which is missed on axial due to angle of the slices. EMG + for L5S1 nerve root irritation. Recs discectomy and explains the failure of radiologist to interpret the HNP. **Berliner 8-19-04:** LBP, no leg pain recorded. Decreased AJ, spasm, SLR + left “causing radicular type complaints down her leg to her toes.” Decreased sensation to lateral left foot and heel. Weak toe flexors and gastroc. MRI: on sagittal a “large disc herniation at L5S1” no well seen on axials because of angle of the slices. EMG: “... indicates that there is an L5S1 nerve root irritation, however there is no L5S1 nerve root. Based on the information, I believe the EMG is making reference to the S1 nerve root radiculopathy. That would be consistent with the physical exam findings.” (the Stone, Loughlin & Swanson, attorneys at law report state that the “Carrier feels it is grossly inappropriate to re-interpret a test in this manner, without even speaking to the person who performed it, and then to state your re-interpreted diagnosis as being fact.” They refer to Dr. Berliner’s reference to the L5-S1 nerve). **Alamed Khalifa, MD, 8-27-04:** Did not mention lifting the specific object, i.e. coil. Does not look at the MRI, “revealed slight posterolateral disc bulge on the left side at the L5S1 level, minimal in extent and of questionable clinical significance. No disc herniation ... is demonstrated. Mild to moderate degenerative changes of the facet joints at the L45 and L5S1 levels which may represent a source of symptoms.” EMG findings “suggestive of L5S1 nerve root irritation bilaterally/o LBP left hip and left knee. 8/10. Pain sitting, standing, sleeping and bending. SLR at 65 degrees bilat. Sitting SLR 85 degrees bilat. Sensory normal. DTR’s OK. Right calf > left by 0.8cm. 5/5 multiple groups. Heel walk with difficulty. Toe walk without difficulty. No Waddell signs recorded. Performed EMG because “...I disagree with conclusion of previous EMG, which is inconsistent with my evaluation today.” EMG by Suzanne Page, MD indicates “no evidence of lumbar radiculopathy...” FCE shoed pt can safely perform her job as an assembly line worker in heavy strength and medium demand level. Establishes MMI on 8-27-04 with 0% IR. **Suzanne Page, MD EMG/NCV:** no

radic (including paraspinals). **Dr. Torres, DC 9-1-04:** pt c/o bilateral leg to midcalves. **Dr. Torres, DC Letter of Rebuttal 9-15-04:** letter of appeal: documents + SLR by Drs. McMillan, Torres, Payan, who along with Drs Athari and Berliner also diagnose patient with lumbar radiculopathy, HNP etc. **Ajay Aggarwal, MD 9-23-04:** 6-9/10. Doesn't record leg distribution. Pt is dissatisfied with QOL. PE difficult to understand, see report (seems poor quality). **Leonard Hershkowitz, MD, 9-28-04:** no record of lifting the coil. MRI report only: bulges at every level, no left S1 nr involvement. Dx: lumbar strain, no evidence of permanent structural damage. DDD multilevel. No treatment was appropriate after the initial PT. ESIs, EMG not reasonable. The injury "was soft tissue, should have resolved within a month or two. Speculates that ongoing pain is from "disease of life issues..." **Dr. Torres, DC 10-4-04:** LBP and left leg to the foot. Radicular pain. Numbness. PE: decreased sensation to left dermatome L3, L4, and L5. MMT 4/5, ? groups. **Walter Long, MD, 11-24-04:** LBP and left leg to foot posteriorly. Cramping. Berliner recommended discectomy. PE: decreased sensation to the left dermatomal regions. DTRs OK. + SLR at 40 degrees left. Recommends PT active exercise and meds. **Berliner 12-2-04:** positive SLR and decreased sensation S1 distribution. Weakness of toe flexors and gastroc on left. MRI and EMG correlates. MRI findings as read by Dr. Knudson, implies that this MD agrees with his interpretation. Requests discectomy. Concentra letters of denial 12-15-04. Rationale: two MRI reports don't reconcile with the requester's statement. EMG showed paraspinal muscle changes only. "There were no radicular findings" therefore this is not a reliable positive test. No documentation of a nerve root compression to verify surgical decompression, nor implant of a spinal canal catheter. - **Walter Long, MD, 12-23-04:** c/o LBP and bil legs. Brief PE: MMT 5/5. **Dr. Rosenzweig. Concentra letter 12-30-04** denial rationale: MRI showed only slight disc bulge on the left, minimal in extent, therefore of questionable clinical sig. EMG legs normal. Dr. Berliner 1-10-05: MRI reviewed and with radiologist (whose initial reading was of ... "the axial views only". Both feel MRI show clear evidence of an HNP. EMG also correlates well with the HNP L5-A1. Recommends myelo-CT. **Stone, Loughlin & Swanson, attorneys at law 3-31-05:** states that the opinions of Dr. Sklar and Dr. Hershkowitz along with the MRI and EMG results provide "overwhelming medical evidence establishing that this is simply a soft tissue injure that has now resolved." Attacks Dr. Berliner: his "gross mischaracterization of the medical records." Says that "Thus, neither of the CMGs that have been performed in this case establishes a need for surgery, because there are no neuropathic complaints." **East Side Imaging, Edward Knudson, MD, myelo/CT 2-3-05:** L5-S1 shows a central disc protrusion of about 2 mm. No S1 nerve involvement noted. **Andrew McKay, MD 2-18-05:** LBP, left leg pl thigh, lateral calf into dorsum and plantar foot with numbness. PE SLR + left at 45 degrees, sensory OK, 5/5, DTRs OK. Heel and toe OK. Recommends transforaminal ESIs. **William Hicks, DC, 3-18-05:** C/o LBP and leg pinup: + SLR left, sensory decreased globally left, MMT 5/5, heel and toe OK.

REQUESTED SERVICE

Proposed decompression L5-S1, left. **Concentra 12-15-04** denies this procedure because: 1. two MRI reports do not reconcile with the requesters statement, 2. EMG showed no radicular findings, only paraspinal muscle changes, 3. no actual documentation of a nerve root compression, and on **12-30-04:** 4. MRI showed only slight posterolateral disc bulge on the left, minimal in extent and of questionable clinical significance, 5. objective and subjective findings do not justify the requested procedure is requested for this patient.

DECISION

The reviewer agrees with the determination of the insurance carrier in this case. The reviewer does not think that the patient should have surgery at this time.

RECOMMENDATION

The reviewer recommends that this patient have a Second Surgical Opinion by a board certified spine surgeon who should personally examine this patient, review the results of the EMG/NCV tests as well as the hard copy films of the imaging tests (the MRI of 5-12-04 and the myelo/CT of 2-3-05). The tie breaker should be a surgeon because he is the only physician who can determine the significance of the imaging in this case.

BASIS FOR THE DECISION

Much was been made by the carrier's physicians and attorneys of the MRI results, the EMG interpretation, and the significance of the objective and subjective findings. In my opinion, most, if not all of Drs. Sklar, Garcia, Hershkowitz, Rosenzweig, and Khalifa's as well as attorney H. Douglas Pruett's conclusions are incorrect with regard to 1. the interpretation of the MRI, 2. the interpretation of the EMG, 3. the conclusion that this patient does not have a lumbar radiculopathy, and 4. that this patient has a lumbar "strain" which resolved within 2 months of the injury.

In my opinion,

1. With regard to the MRI, Dr. Berliner has the best position to interpret this study. The advantage he has over all of the other physicians is that not only has he taken a history, and performed a physical exam on this patient, he has personally looked at the actual MRI films. None of the other physicians looked at the films. Some imaging findings are subtle and the advantage of the surgeon is that he can focus his attention on the suspected nerve root. His suspicion of a specific nerve root involvement sometimes allows a surgeon to see what even the radiologist can't. Apparently, Dr. Berliner found corroboration by a second opinion radiologist who agreed that there was a herniation. All of the other physicians relied solely on the original radiologist, Dr. Cubberly, and have held his interpretation as indisputable. These physicians, none of whom are identified as surgeons, are not familiar with either reading these studies as a surgeon would, nor do they understand that "subtle" findings on imaging can be of absolute clinical significance. They make statements of absolute certainty without having personally looked at the evidence. It is my suspicion that these physicians do not routinely interpret their own imaging by reading films. They depend on the radiologist. But the standard of care for a surgeon is different. A surgeon should always read the images himself, and then read the radiologist's interpretation. If the two do not fit, then he should do as Dr. Berliner did, request an overread by another radiologist, and consider another imaging test, like a myelo/CT. Radiologist reports, by the nature of their terminology, generate controversy and differences in meaning from one clinician to another. There is no substitute for personal review of the films. Dr. Berliner is absolutely right when he states that the angulation of the cuts may have led to the radiologist's failure to see the herniation. Surgeons realize that advanced imaging is not 100% accurate in determining the degree of nerve involvement, because we are able to directly visualize the pathology in the operating room under the microscope. This unique experience sometimes reveals a much more compelling problem than the lower resolution advanced imaging, eg MRI.
2. With regard to the EMG test, Dr. Berliner correctly interprets the test as being consistent with an S1 radiculopathy, even though only paraspinal findings were present. Unfortunately, too much emphasis is placed on EMG findings as being proof of a lumbar radiculopathy. An EMG will only be positive if there is actual denervation of a nerve root in this situation. And even if there is denervation, the EMG will be abnormal only temporarily. I don't know of any studies of the prevalence of positive EMG findings for patients with lumbar radiculopathy, but a significant percentage of patients with lumbar radiculopathy will have normal EMG/NCV tests. A normal EMG is not an absolute exclusionary test for the absence of lumbar radiculopathy. Attorney Pruett's scathing declaration of Dr. Berliner's clinical interpretation is both incorrect and out of line.
3. With regard to whether or not this patient had or did not have a lumbar radiculopathy, I believe that the patient does. This diagnosis is based on both subjective and objective information. Most of the providers who saw this patient do an adequate job of arriving at the diagnosis of a lumbar radiculopathy based on both subjective and objective findings. The providers who diagnosed lumbar radiculopathy include Drs. Berliner, Torres, Payan, Aggarwal, Long, McKay, and Hicks. All of these doctors record both symptoms and physical exam findings consistent with a lumbar radiculopathy. The only physician who both examined this patient and concluded that the patient did not have a lumbar radiculopathy is Dr. Khalifa. None of the other dissenters examined this patient.
4. With regard to the patient's diagnosis, Drs. Hershkowitz and Sklar both diagnose this patient as having a "lumbar strain." Furthermore, they state that lumbar strains are injuries that resolve in one to two months. In other words, by branding the patient as having a lumbar strain and that a strain resolves in two months, they say that this patient is no longer having pain related to the compensable injury. They are wrong because:

- a. A diagnosis of “lumbar strain” is a very imprecise diagnosis. This patient has a number of factors which weigh against this diagnosis including the symptoms of lumbar radiculopathy discussed above. A true lumbar strain, i.e. a muscle injury should not cause symptoms radiating below the knee to the foot, reproduced by the straight leg raising test. In my opinion, based on the mechanism of injury, the activities which aggravate the patient’s symptoms, the physical exam findings, and the imaging findings, this patient has a painful lumbar disc and a lumbar radiculopathy.
- b. The expected natural history of discogenic pain with radiculopathy is measured in months and can last greater than a year. But the expected natural history is based on a large population of patients, and the actual natural history for the individual patient falls somewhere within a broad range.

Finally, Dr. Sklar’s report deserves further comment. With regard to the chiropractor Dr. Torres, Dr. Sklar says,

“One wonders why the findings which the chiropractor made on physical examination were not reproducible on other examinations that the claimant had undergone.”

Unfortunately, Dr. Sklar fails to document the medical records that he reviewed. But according to the records that I received, both Dr. Payan and Dr. Torres had documented physical exam findings consistent with lumbar radiculopathy (see above). In addition, Dr. Torres’ letter of 9-15-04 documents multiple providers who concur with his physical exam findings. It sounds to me that Dr. Sklar is questioning the veracity of Dr. Torres’ medical records.

Later in his report, Dr. Sklar says,

“It appears that the injury was a lumbar strain. That sort of injury would reasonably have resolved within one to two months with or without treatment. Clearly, then, this claimant’s compensable injury would reasonably have resolved by 6/07/04. The fact that this claimant continues to complain of pain does not change the fact that the compensable injury would reasonably have resolved by that point in time. Quite possibly, he has some other reason for having back pain, which is an incredibly common symptom in the United States at this point in time. We certainly don’t need an injury at work to explain why this claimant has complaints of back pain. Clearly, then, the claimant’s compensable injury has resolved, as would be reasonably expected looking at the evidence-based medical literature such as The Official Disability Guidelines. As such, the ongoing treatment would not be reasonable or necessary in this case. Assuming for a moment that this claimant does continue to suffer from the effects of a compensable injury, which he clearly does not, it is clear that ongoing treatment would not be reasonable or necessary even in that case.” Further, “Pain is not a reason not to work. There is nothing in this file suggesting that this claimant had any sort of significant injury to the structure of his body which should have necessitated more than two days off work.”

Without having seen or examined this patient, Dr. Sklar has misdiagnosed this patient with an imprecise diagnosis, and on that basis, dictates that the patient will fit a precise natural history of healing and even states the exact date by which healing will have occurred. He further states that because back pain is incredibly common, that the mere prevalence of back pain in the United States explains why this patient is still symptomatic.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee’s policy.

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,
ZRC Services Inc



Dr. Roger Glenn Brown
Chairman & CEO

Cc:

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YOUR RIGHT TO REQUEST A HEARING

Either party to 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 (28 Tex. Admin. Code 142.5(c)).

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 142.5(c)).

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

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

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

Name/signature

I hereby certify, in accordance with TWCC 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 TWCC via facsimile, U.S. Postal Service or both on this _____ day of _____, 2005.

Name and Signature of Ziroc Representative: