

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1371-01
Name of Patient:	
Name of URA/Payer:	Liberty Mutual Fire Insurance
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Peter Polatin, MD

May 17, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedic surgery. 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,

Michael S. Lifshen, MD
Medical Director

cc:

Robert J. Henderson, MD
Peter Polatin, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

Records from the PRIDE program in Dallas indicate that Mr. ____ was seen for a mental health evaluation on 5/17/04 in relation to an injury of _____. He was injured when a light fixture fell from a ceiling and hit him on the head. He developed neck and back symptoms. The mental health evaluation demonstrated evidence of significant depression, anxiety, somatization, with a statement indicating that the claimant suffered cognitive and affective sequelae that had led to feelings of depression and anxiety.

On 10/22/04 the claimant had a designated doctor exam by Dr. Guerrero. The history was the same with the notation that he had had neck and back pain since the injury. He had undergone conservative care for approximately seven months and work hardening and one epidural steroid injection. EMG study on 6/8/04 was said to have showed a mildly slowed H reflex suggestive of a left S1 nerve root irritation, but without denervation potentials in the S1 distribution and essentially normal EMG. There was no evidence of a peripheral neuropathy or myopathy of the left lower extremity. He was felt to have a deconditioned state and a chronic pain syndrome. He previously had an EMG of the left median nerve showing a median neuropathy at the wrist. X-rays of the hip had shown evidence of degenerative change in the left hip. MRI of the lumbar spine on 7/24/03 showed moderate degenerative disc narrowing and desiccation at L5-S1 with a posterior annular tear and a central 5mm disc herniation without stenosis or neural impingement.

Post-discogram CT done on 3/24/04 showed an abnormal annulus complex at L5-S1 with a radial tear of the posterior annulus and a 3mm posterior soft tissue disc protrusion. Lumbar spine films showed a rudimentary disc at S1-S2.

Past medical history was positive for diabetes mellitus. Chief complaints were low back pain and left shoulder pain and left arm and wrist and hand pain. Examination showed a positive straight leg raising test bilaterally, a decreased lumbar range of motion, some weakness in the upper extremities, a slightly diminished left Achilles reflex. It was felt that he was not at MMI. It was the opinion of Dr. Guerrero that he would benefit from surgical treatment for his back problem and also needed a pain management program. Dr. Henderson saw the claimant on 6/25/04, noting that he had been denied for surgery twice. He weighed 296 pounds. He has had a lap band procedure, but had not lost any weight yet. No physical exam was detailed. Dr. Henderson recommended a posterior lumbar interbody fusion at L5-S1. Dr. Henderson reviewed his previous radiographic studies, noting the MRI on 7/27/04 showed a 5mm disc protrusion at L5-S1 and a previous MRI on 9/11/03 had shown a disc bulge at L5-S1. Hip films had shown degenerative arthritis and discography on 7/24/04 had apparently shown abnormalities at L5-S1 with concordant pain at that level.

The patient had failed two epidural steroids. On 11/5/04 Dr. Henderson saw the patient again and did not record a physical exam other than blood pressure and weight. The patient was noted to be having significant pain problems. He apparently had been in the PRIDE program, but had left the program, as he was not apparently able to tolerate it. He recommended that the claimant lose 40-50 pounds of weight before he had surgery. On 1/19/05 Dr. Henderson saw the patient again and again recommended proceeding with surgical intervention. Again, there is no description of a physical examination or any significant physical findings.

On 8/10/04 there is a letter from the PRIDE Program indicating that the patient had been discharged from the program. The patient apparently completed fourteen visits. He was taking Seroquel, Arthrotec, Neurontin, and Paxil. Ongoing barriers to recovery were noted to be high pain sensitivity and persistent focus on somatic complaints.

On 5/11/04 Dr. Polatin examined the patient and noted complaints of low back pain. He had superficial back tenderness and a great deal of non-organic behavior. He had a hypoactive left ankle jerk, but had no sensory changes and had a stocking hypesthesia on the left and to

some degree on the right leg. He had limited lumbar range of motion. The diagnosis was chronic left lumbar radicular syndrome, chronic deconditioning, and chronic pain syndrome with medical and psychological features. He was felt to have extended disability with non-organic presentation and emerging depression and anxiety. Dr. Polatin continued to treat him through Summer 2004. He was being treated for depression with Paxil. He noted that a lower extremity EMG and nerve conduction study performed by Dr. Adams was negative in spite of physical findings suggestive of a left S1 nerve root irritation. He again felt the patient had lower back problems, cervical problems, deconditioning, and a chronic pain syndrome with medical and psychological features. On 7/24/04 Dr. Polatin saw the patient again with physical findings showing inhibited straight leg raising, particularly on the left. He continued to have superficial tenderness and other non-organic Waddell signs on exam and a hypoactive left ankle jerk. He continued to prescribe Seroquel, Paxil and Neurontin and changed him to Bextra. On 8/16/04 Dr. Polatin noted persistent complaints of pain. He was noted to have left upper extremity problems. He reported that complicating the picture was depression with mood congruent psychotic features and some auditory hallucinations, which had been controlled with Paxil and Seroquel. He was taking Neurontin for neuropathic pain. He was noted to be diabetic. The assessment was unchanged. The patient was referred for a surgical opinion.

On 10/26/04 he was seen back for follow up. He noted that Dr. Henderson had recommended a fusion. He continued to have low back pain. Physical exam showed restrictions of cervical and lumbar mobility. The diagnoses were unchanged. On 3/21/05 Dr. Polatin noted that the patient had seen Dr. Henderson who had recommended surgery, but surgery apparently had been denied on the basis of his obesity.

On 2/7/05 Dr. Bayles reviewed a request for authorization for L5-S1 laminectomy and posterior fusion transverse process fusion. He reviewed the patient's clinical history. He felt that the treatment was not medically reasonable or necessary. He noted that there was no evidence of lumbar instability in the medical record and felt that surgical intervention was not medically reasonable or necessary. This was based on OTG and ODG guidelines indicating that spinal fusion in the absence of fracture or instability was not recommended.

On 2/24/05 another review of the request for surgery was performed by Dr. Shirley. He also felt that the surgery was not medically necessary. He stated that the claimant had a comorbidity, which would adversely compromise the outcome of the procedure and increase the risk of complications. This comorbidity was his excessive weight and it was felt that surgery should not be considered until he had lost weight. He quoted the ACOEM Second Edition guidelines indicating that surgical consultation would be appropriate for patients with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, preferably with accompanying objective signs of neural compromise.

REQUESTED SERVICE(S)

Posterior lumbar interbody fusion with posterior decompression and transverse process fusion, posterior internal fixation and bone graft.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

As noted by the previous reviewers there is no evidence in the medical record of spinal instability, thus rationale for fusing the involved segment is absent. The surgery has been proposed based upon the findings of his positive discogram, which apparently showed concordant pain. Evidence for the lack of reliability of discography is available in the AHCPR guidelines and from the Cochrane Collaboration. These reviews would suggest that there is no reliable information to support the use of diagnostic discography.

Further data which would support the unreliability of fusion for treatment of chronic spinal pain are found in the article by Brox, et al. September 1, 2003 in *Spine*. In that article it was determined that lumbar fusion did no better than lectures about safety activities and exercises. Furthermore Fitzler's award winning study in 2001 found limited improvement with fusion of 26% in the operative group compared to a placebo group at six months. These results deteriorated to only a 15% difference at two years. This limited improvement must be compared to the risk of substantial complications, reported to be 17%, with 9% of the surgical complications being either life-threatening or requiring immediate re-operation. Based upon the claimant's obesity, his psychological

distress in terms of anxiety and depression, lack of concordance between imaging studies and evidence of neuropathy in the lower extremity, surgery for this condition is not medically reasonable or necessary. Further evidence to support this conclusion is available from Fritzell, *Spine*, 2001, Volume 26. In this article the results indicated that there was still a considerable amount of both pain and disability reported two years after treatment with fusion and that lumbar fusion in this patient group was found to very seldom cure the patient.

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 18th day of May 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell