



IMED, INC.

1819 Firman • Suite 143 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

NOTICE OF INDEPENDENT REVIEW

NAME OF EMPLOYEE: _____
IRO TRACKING NUMBER: M2-06-1270-01
NAME OF REQUESTOR: Warren Parker, M.D.
RESPONDENT: City of Bryan / Dean Pappas & Associates
DATE OF REPORT: 06/13/06
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 cases 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 an M.D. physician reviewer who is Board Certified in the area of Neurological Surgery 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:

- MRI report dated 01/27/06 from Advanced Diagnostics, 1 page.
- Letter from Neurosurgical Group of Texas to Dr. Landsman dated 02/02/06, 2 pages.
- Letter from Dr. Parker dated 02/02/06, 1 page.
- Lumbar MRI dated 04/20/06, 2 pages.
- Spectrum Investigations report sixteen pages.
- Letter from Neurosurgical Group of Texas to Dr. Landsman dated 02/02/06, 2 pages.

Clinical History Summarized:

The employee is a 33 year old male who reportedly sustained an injury on ___ while lifting a stretcher. The employee reported the onset of low back pain, right buttock pain, and right leg pain. He also had subjective complaints of right leg weakness.

An MRI was performed on 01/27/06 and revealed disc desiccation with L4-L5 disc bulge that flattened the anterior thecal sac, and facet arthropathy with no evidence of central stenosis or foraminal stenosis. At L5-S1, there was identified a subarticular disc extrusion with flattening of the thecal sac and displacement of the traversing right S1 nerve and neural foraminal narrowing at the level of the disc space bilaterally.

The employee was referred for a neurosurgical consultation with Dr. Warren Parker. The physical examination of the lumbar spine revealed limited range of motion in flexion and extension secondary to back and right leg pain, antalgic gait, and bilateral straight leg raise produced exquisite pain complaints, right greater than left. The neurological examination reported no motor or sensory deficits, and all reflexes were 2+ and symmetrical. Dr. Parker's impression was right L5-S1 extruded disc and recommendation was made for surgical excision.

In April, 2006, surveillance of the employee was conducted and reported no difficulty with activities of daily living and even strenuous activity.

Disputed Services:

Preauthorization denied for lumbar laminectomy.

Decision:

Lumbar laminectomy denied.

Rationale/Basis for Decision:

Objective findings on imaging studies revealed a disc lesion at L5-S1; however, there were no neurologic deficits noted on clinical presentation. There was no documentation that any attempts at conservative care with physical therapy or epidural steroid injections were made prior to pursuing surgical intervention. The proposed surgical procedure is premature and not clinically indicated at this time.

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.

References:

ODG Discectomy/Laminectomy recommended for indications below. Surgical discectomy for carefully selected patients with sciatica/radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. (**Gibson-Cochrane, 2000**) (**Malter, 1996**) (**Stevens, 1997**) (**Stevenson, 1995**) (**BlueCross BlueShield, 2002**) (**Buttermann, 2004**). Standard discectomy and microdiscectomy are of similar efficacy in treatment of herniated disc. (**Bigos, 1999**) (Note: Surgical decompression of a lumbar nerve root or roots may include the following procedures; discectomy or microdiscectomy (partial removal of the disc) and laminectomy, hemilaminectomy, laminotomy, or foraminotomy (providing access by partial or total removal of various parts of vertebral bone).

ODG Indications for Surgery – Discectomy/Laminectomy:

1. Symptoms/Findings (confirm presence of radiculopathy), requiring ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps weakness/mild atrophy.
2. Mild to moderate unilateral quadriceps weakness.
3. Unilateral hip/thigh/knee pain.

B. L4 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy.
2. Mild to moderate unilateral quadriceps/anterior tibialis weakness.
3. Unilateral hip/thigh/knee medial pain.

C. L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy.
2. Mild to moderate foot/toe/dorsiflexor weakness.
3. Unilateral hip/lateral thigh/knee pain.

D. S1 nerve root compression, requiring one of the following:

1. Severe unilateral foot/toe/planar flexor, or hamstring weakness/atrophy.
2. Moderate unilateral foot/toe/plantar flexor, or hamstring weakness/atrophy.
3. Unilateral buttock/posterior thigh/calf pain.

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiological evaluation and physical examination findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture.
- C. Lateral recess stenosis.

Diagnostic imaging modalities, requiring ONE of the following:

1. MR imaging.
2. CT scanning.
3. Myelography.
4. CT myelography & x-ray.

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (≥ 2 months)
- B. Drug Therapy, requiring at least ONE of the following:
 - 1. NSAID drug therapy.
 - 2. Other analgesic therapy.
 - 3. Muscle relaxants.
 - 4. Epidural steroid injection (ESI).
- C. Support provider referral, requiring at least ONE of the following:
 - 1. Manual therapy (massage therapist or chiropractor).
 - 2. Physical therapy (teach home exercise/stretching)
 - 3. Psychological screening that could affect surgical outcome (**Fisher, 2004**).

ACOEM Chapter 12 Direct methods of nerve root decompression include laminotomy, standard discectomy, and laminectomy. Chemonucleolysis with Chymopapain is an example of an indirect method. Indirect chemical methods are less efficacious and have rare but serious complications (e.g., anaphylaxis, arachnoiditis). Percutaneous discectomy is not recommended because of proof of its effectiveness has not been demonstrated. Recent studies of chemonucleolysis have shown it to be more effective than placebo, and it is less invasive, but less effective than surgical discectomy; however, few providers are experienced in this procedure because it is not widely used anymore. Surgical discectomy for carefully selected patients with nerve root compression due to lumbar disc prolapse provides faster relief from the acute attack than conservative management, but any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. Given the extremely low level of evidence available for artificial disc replacement or percutaneous endoscopic laser discectomy (PELD), it is recommended that these procedures be regarded as experimental at this time.

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.

Case No.: M2-06-1270-01

Page Six

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.

If you are disputing the 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.

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 June, 2006 from the office of IMED, Inc.

Sincerely,



Charles Brawner
Secretary/General Counsel