

MATUTECH, INC.

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April 12, 2006

Rebecca Farless
Texas Department of Insurance
Division of Worker's Compensation
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR Tracking #: M2-06-1042-01
DWC#: _____
Injured Employee: _____
DOI: _____
IRO#: IRO5317

Dear Ms. Farless:

Matutech, Inc. has performed an Independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, the injured employee, the 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.

Information and medical records pertinent to this medical dispute were obtained from Specialty Risk Services and Robert Henderson, M.D. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by the physician who is licensed in orthopedics, and is currently on the DWC Approved Doctors List.

Sincerely,



John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by Robert Henderson, M.D.:

Preauthorization request for surgery (02/13/06)
Designated doctor evaluation (10/17/05)
Clinic notes (12/05/05 - 02/27/06)
Radiodiagnostic study (04/26/05)
Procedure note (11/14/05)

Information provided by Specialty Risk Services:

Clinic notes (07/18/05 – 02/10/06)
Radiodiagnostic study (04/26/05)
Procedure note (11/14/05)
Designated doctor evaluation (10/17/05)

Clinical History:

This is a 35-year-old Hispanic male, who had a sudden onset of lower back pain while pulling and jerking some frames out of their containers in a bent over position.

2005: Magnetic resonance imaging (MRI) of the lumbar spine revealed: (a) dehydrated discs at L4-L5 and L5-S1; (b) a 2-mm generalized disc protrusion at L4-L5 producing generalized compression of the thecal sac, an annular fissure, and mild canal stenosis; (c) a 2-mm generalized disc protrusion and/or spur at L5-S1 that was mildly compressing the thecal sac; (d) bilateral foraminal stenosis at L5-S1, right more than left; (e) a 1-mm annular disc bulge at L3-L4 only slight ridging the thecal sac; and (f) a Schmorl's node in the inferior endplate of L4. Robert Henderson, M.D., noted the patient's current medications were Quinaretic, hydrocodone, Naprosyn and methocarbamol. Dr. Henderson noted the following: The patient had been referred by Brian Saul, D.C., for persistent lower back pain. He had undergone physical therapy (PT) consisting of roller bed treatment, electrical stimulation, heat application, and massage. X-rays of the lumbar spine revealed disc space narrowing at L5-S1 and some narrowing of the facet joints, most predominantly at L5-S1. Dr. Henderson diagnosed lumbar syndrome and spondylosis at L4-L5 and L5-S1. He administered a caudal epidural steroid injection (ESI). Dr. Henderson reported that the patient had been administered two ESIs by Dr. Molina. It was also noted that Karim Meghani, M.D., had placed the patient at maximum medical improvement (MMI) and had assigned an impairment rating (IR) of 5%. The patient was also on Lortab. Dr. Henderson reviewed the MRI findings and noted type I and type II modic changes in the endplates of L4. He recommended a lumbar discogram followed by surgery.

2006: Dr. Henderson noted that the discogram had been denied by the carrier. He provided a thoracolumbosacral orthotic (TLSO) brace and recommended anterior discectomy and interbody fusion at L4-L5 and L5-S1. In an IR evaluation, Dr. Meghani opined that the patient was not at MMI and surgery would be a viable option since conservative treatment had apparently failed to alleviate the pain. Dr. Henderson submitted a preauthorization request for the proposed surgery (total discectomies, interbody fusions, and interbody fixation at L4-L5 and L5-S1 through an anterior approach, and posterior decompression of central stenosis at L4-L5 via total laminectomy). The request was denied for the following reasons: Previous x-rays had revealed no segmental instability to warrant a fusion. There was no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis. The request was not medically reasonable and necessary. On February 27, 2006, Dr. Henderson indicated that the patient had undergone an inadequate amount of conservative care, and should not be refused his surgery. On March 1, 2006, a reconsideration request was denied.

Disputed Services:

L4-L5 and L5-S1 procedures: anterior body fusion, retroperitoneal exposure, discectomy, anterior body fixation, posterior decompression, and transverse process fusion. Posterior internal fixation at L4-L5.

Explanation of Findings:

Please refer to the above summary.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:

My recommendation at this time is to overturn the denial of the proposed intervention. However, I think it would be a grievous mistake if the patient were to undergo the fusion mentioned without first undergoing provocative discography performed under pressure monitoring by an unbiased physician preoperatively. Although discography has brought about significant controversy in the past, new studies, including those by Derby et al Guyre, et al and O'Neil et al in 2003 through 2005 have shown significant validity of this procedure when performed with pressure monitoring on patients without chronic pain behaviors or psychometric abnormalities. It appears at this time that a request is being provided for surgical intervention without the benefit of a discography, secondary to its being denied preoperatively. I feel most preauthorization physicians are untrained or unable to provide an adequate opinion regarding lumbar discography and spine fusions as they are not fellowship trained spine surgeons who have trained in a more recent era. As a fellowship trained spine surgeon from the Mayo Clinic, I have found lumbar provocative discography to be invaluable in performing successful surgeries to address discogenic back pain. The comment made by the previous reviewer that stated no segmental instability was noted to warrant a fusion, and there was no scientific evidence about the long term effectiveness of any form of decompression or fusion for degenerative lumbar spondylosis is wholly incorrect. There is more than adequate literature to substantiate the use of decompression in patients that have degenerative

spondylosis with significant stenosis resulting in neurogenic claudication or radiculopathy or a combination thereof. Additionally, degenerative lumbar spondylosis alone is not an indication for a fusion; however, patients that have significant antero or retrolisthesis after undergone a decompressive operation should be treated with a fusion with or without instrumentation to prevent iatrogenic instability. Additionally, patients that have significant discogenic pain that arises as a result of minor trauma to the disc that may have already been desiccated from the degenerative process and have discogenic proven concordant pain on provocative discography, have significant success in the hands of the right spine surgeon. Studies have shown and continue to validate the use of fusions for discogenic pain proven by lumbar discography in two or one level disease showing a rate of good to excellent outcomes on the order of 87 to 93%. There is controversy over whether or not a three level fusion for discogenic pain is reasonable, but even in that scenario there is evidence to show that 70% of patients have good to excellent outcomes. Some studies have even shown up to 86% good to excellent outcomes with equivalent success with two or three level fusions as reported by Pinto et al. In any event, patients that have lumbar discography that shows multiple levels (more than three) should not be treated with a fusion procedure to address their discogenic pain as a fusion will likely prove unsuccessful. However, in my opinion, it is clear that one or two level disease is relatively clear as when shown to be concordant on provocative discography at low pressures with a pressure differential between opening and closing pressure of less than 24 psi with severe concordant pain and with abnormal morphology, these studies have been shown to be dramatically successful, decreasing the false positive rates of provocative discography to less than 10% as reported by O'Neil et al in Spine of 2004, as a practicing spine surgeon who trained at the Mayo Clinic, would routinely use provocative discography and had little to no failures in that regard when choosing patients for this type of procedure. In my own personal practice, I continue to employ provocative discography performed with pressure monitoring and have had no clinical failures as of yet. I do feel the indications are extremely strict and do not provide the surgical procedure for a majority of patients. However, in those patients with no psychometric disturbances who have no chronic pain behaviors who have provocative discography that clearly shows abnormal morphology, severe concordance of pain and low pressure threshold differentials, the outcomes have been extremely successful. This should be limited, in my opinion, to three, two or one level disease or abnormalities and should not extend past the three level procedure. I do find it very rare to recommend a three level procedure, but do routinely perform two level fusions for discogenic pain proven by lumbar discography. I would certainly recommend the patient undergo provocative discography and a fusion procedure as recommended by Dr. Henderson only if concordant pain with low pressure differentials (less than 25 psi between opening and closing pressures) are noted at two levels or one level. A three level fusion should only be considered in the setting of severe unremitting pain that limits the patient from performing even normal activities of daily living. Four level disease should likely not be performed for this indication. A consideration should also be made for the L3-4 level which does not appear to be completely normal, based on the readings provided, as some surgeons do not believe in stopping their fusions at a degenerated segment. There does appear to be an annular tear at L4-5 as noted on the reports provided, and although the high intensity zone is not always a predictor of discogenic pain, it can lead one to the assumption that there may be a source of the patient's unremitting pain. In Spine

February of 2006, it has been noted that the morphology and the pathologic makeup of a degenerated disc is not the same in patients who have discogenic pain versus those who do not. Although the appearance of the disc may be similar on MRI, the finding internally and the pathologic findings within the patients who have discogenic pain show significant abnormalities with respect to the presence of tumor growth factor beta I, hyperplastic growth factor, abnormal granulation tissue, macrophages and monocytes that are not present in a patient who has a standard degenerated disc. In that regard, it is clear that there is a difference in the actual anatomic makeup of patients' discs who have discogenic pain and those who do not.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

Please refer to the above diatribe on my opinion regarding lumbar discography and the performance of fusions for patients with discogenic pain. There are many indications for surgical fusion of the lumbar spine, one of which is instability; however, many other indications including removal of more than 50% of the facet joint, axial or significant back pain in the setting of a patient with radiculopathy, discogenic pain proven limited to three levels or less proven by provocative discography with pressure monometry, significant spondylolisthesis/hypermobility and clinical instability. It is a falsehood to suggest that the only indication for a fusion is instability. I do feel it is excessively important that the patient be seen by a fellowship trained spine surgeon and that any procedure performed for discogenic pain be indicated and performed by a fellowship trained spine surgeon versus a general orthopedic surgeon or a neurosurgeon with no spine surgery fellowship background. Once again, this is my personal philosophy as a fellowship trained spine surgeon who has had significant clinical success in treating patients of this nature.

The physician providing this review is an Orthopedic Surgeon. The reviewer is national board eligible by the American Board of Orthopedic Surgeons. The reviewer has been in active practice for 9 years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile, a copy of this finding to the provider of records, payer and/or URA, patient and the Texas Department of Insurance.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to Matutech for review, the published scientific medical literature, and other relevant

information such as that available through federal agencies, institutes and professional associations. Matutech assumes no liability for the opinions of its contracted physicians and/or clinician advisors the health plan, organization or other party authorizing this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

Your Right To Appeal

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 30 days after the date on which the decision that is the subject of the appeal is final and appealable. 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.

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