

MATUTECH, INC.

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April 24, 2006

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

Re: Medical Dispute Resolution
MDR Tracking #: M2-06-1083-01
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 Dallas Spine Care, and Flahive, Ogden, and Latson. 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 Dallas Spine Care:

Surgery note (07/19/04)
Radiodiagnostics (04/14/05 - 07/18/05)
Office notes (07/22/05 – 01/18/06)

Information provided by Flahive, Ogden, and Latson:

Procedure notes (12/05/03 – 07/19/05)
Hospitalization notes (07/16/04 – 07/22/04)
Diagnostic notes (07/16/04 – 07/18/05)
Office notes (06/15/04 – 01/18/06)
Independent medical examination (06/06/05 – 11/02/05)
FCE (10/05/05)

Clinical History:

This is a 49-year-old black female who injured herself on ____, when she slipped and fell to the floor with her right leg bent up underneath her.

2003: In December, Jose Reyes, M.D., diagnosed right sacroiliitis and administered a right sacroiliac (SI) joint injection.

2004: In June, Son Nguyen, M.D., a pain specialist, noted tenderness from L4 through S1 and limited lumbar range of motion (ROM). The sensations were decreased along the L5/S1 dermatome. Straight leg raising (SLR) tests were positive bilaterally. Dr. Nguyen diagnosed symptomatic hardware, lumbar radiculopathy, status post lumbar fusion, depression, and insomnia secondary to the pain. He refilled Lortab, Soma, Ambien, Zoloft, and Vioxx. On July 19, 2004, Mark McDonnell, M.D., performed removal of posterior spinal segmental hardware and posterolateral arthrodesis and instrumentation at L5-S1. The postoperative diagnosis was pseudoarthrosis at L5-S1 and status post posterior instrumentation and fusion at L5-S1 for nonunion. William Donovan, M.D., an orthopedic surgeon, recommended a home exercise program (HEP) for increasing back pain. Meanwhile Dr. Nguyen continued to treat the patient with the same medications and added Senokot.

2005: In April, computerized tomography (CT) of the lumbar spine revealed status post laminectomy at L5-S1 with two-level pedicular fixation device in place at L5 and S1 bilaterally. Dr. Nguyen prescribed Lidoderm patch. In an independent medical evaluation (IME), Robert Whitsell, M.D., stated that follow-ups with an orthopedic surgeon and the ongoing medications were reasonable and necessary. However, ongoing

physical therapy (PT) was not felt to be necessary. William Francis, Jr., M.D., reviewed the CT findings and noted lucency within the cage itself suggesting a nonunion. There was no bridging bone posteriorly and there was some exiting of the left pedicle screw outside the vertebral body segment. A lumbar CT myelogram revealed mild narrowing of the dural fat at L4-L5 just above the hardware and artifacts from internal fixation hardware with successful posterior fusion at L5 bilaterally.

Robert Henderson, M.D., noted the following: Previous spine surgeries: On October 4, 2000, right hemilaminectomy for a herniated nucleus pulposus (HNP); on May 30, 2002, re-exploration on the right then on the left, and a posterior lumbar interbody fusion (PLIF) at L5-S1; on March 3, 2003, re-exploration of the fusion and re-do pedicle fixation. She recently attended six weeks of PT. In June 2000 and August 2001, discograms showed an isolated pain generator at L5-S1. Dr. Henderson assessed probable retained symptomatic pedicle fixation at L5 and S1 and an intact fusion mass at L5-S1, and rule out facet arthropathy above the fused level. He recommended a hardware block bilaterally. He stated that the patient was a potential candidate for excision of her hardware and evaluation of her fusion status along with denervation of the facets at L4-L5.

In a functional capacity evaluation (FCE), the patient qualified at a below sedentary physical demand level (PDL) versus a very heavy PDL required for her job. After a hardware block was denied, Dr. Donovan recommended removal of hardware. In a designated doctor evaluation, Herbert Brannan, M.D., reviewed the following records: In August 1999, lumbar discogram revealed a mild disc bulge at L4-L5. The patient also had injured her right knee along with her back. In March 2000, magnetic resonance imaging (MRI) of the right knee revealed grade II signal in the medial meniscus, a horizontal tear in the body of the lateral meniscus communicating with the superior articular surface, a partial tear of ACL, and grade II chondromalacia patella. On April 27, 2000, Dr. Donovan performed right knee arthroscopy with partial lateral meniscectomy, a lateral release and chondroplasty of the patella. In March 2001, due to persistent right knee complaints, he performed another right knee arthroscopy with lateral and partial medial meniscectomy, and further shaving of patella. In 2002, the patient had a series of SI injections. Dr. Brannan stated that the patient was unable to do any type of gainful employment and was totally permanently disabled.

2006: Dr. Henderson noted persistent radiculopathy in the lower extremities and recommended posterior pedicle fixation from L5 through S1 bilaterally and repeat decompression of the L5 nerve roots bilaterally. On February 3, 2006, he placed a pre-authorization request for excision of the internal fixation at L5-S1, re-do posterior decompression, and an evaluation of fusion.

On February 27, 2006, the request was denied by the carrier for the following reason: The myelogram and post-myelogram CT did not show any nerve root compression. On March 1, 2006, Dr. Henderson appealed for reconsideration of the request.

Disputed Services:

Excision of internal fixation at L5-S1, re-do posterior decompression, evaluation of fusion, and intraoperative decision for transverse process fusion at L5-S1.

Explanation of Findings:

As noted above, the patient has undergone four previous operations, all of which included an L5-S1 fusion. Most recently, imaging studies in the form of CT with myelogram revealed a solid fusion at L5-S1 and no compression on any of the neuro elements in the lumbar spine. Ms. Jones continues to have pain and request is currently being made for fifth lumbar spine fusion/fourth lumbar spine revision with primary indication for decompression of the L5 nerve roots. The patient appears to complain of global numbness to the toes and intermittent tingling of the lower extremities but did not appear set any specific radicular pattern.

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

I do uphold previous denial at this time. I would certainly recommend Dr. Anderson pursue a more thorough workup before providing the patient with a fourth revision operation for her lumbar spine and lower extremities vague complaints. The fact that she has undergone a PLIF previously predisposes her to chronic neurologic symptoms as a function of the surgical procedure itself alone, but even without any evidence of epidural fibrosis or recurrent stenosis, the PLIF operation has been known to cause bilateral lower extremity numbness and tingling and weakness. Although a surgical revision may be reasonable, the patient should at minimum undergo electrodiagnostic studies prior to considering any surgical intervention for a potentially chronic, refractory lower extremity neurologic complaint. Additionally, an MRI with suppression of the metallic implants with fast spin echo technique would be advisable to determine if the patient has adjacent level disease at L4-L5 that accounts for her current symptoms versus an L5-S1 level which has been noted to be solidly fused both posteriorly and anteriorly by CT scan. Any significant changes on a lumbar spine MRI may warrant preoperative discography with pressure monitoring to determine the true source of the patient's pain. I do not feel that a repeat decompression at this time would provide the patient with any significant symptomatic relief.

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

Ms. Jones has undergone five operations for her lumbar spine; all of which included a decompression at L5-S1. The chance for epidural fibrosis and increasing neurologic irritation increases with each subsequent procedure as do potential complications such as dural tear and spinal fluid leakage. Although it would be potentially reasonable to perform this procedure and significant objective evidence of compression noted over the L5 or S1 nerve roots been located or identified on radiologic studies, I do not see any evidence at this time that this is in fact the case. I am significantly more suspicious that

the adjacent level at L4-L5 is the culprit of the patient's current symptoms. A whole body bone scan would be reasonable to determine if there is any evidence of pseudoarthrosis that cannot be detected on the CT myelogram. A solid fusion does appear to be evident on CT scan and reconstruction of images however, there is no way to determine with 100% certainty that the patient is solidly fused without an exploration operation. However, the CT scan is the most noninvasive way of determining this, and a bone scan would potentially add to a potential finding of uptake at the previous fusion site suggestive of a pseudoarthrosis as well. The patient would also likely benefit from infection lab secondary to the multiple operations performed in the past, which would include CRP, CBC with differential and ESR to rule out an occult infection as the source of her current pain. I am most suspicious that the patient has L4-L5 adjacent level disease, which warrants further evaluation in the form of MRI with fast spin echo to suppress the metallic artifact and possible lumbar discography with pressure monitoring if the patient is noted to have significant findings of the discs in the suprajacent levels. An operation of this magnitude should certainly be accomplished by a fellowship-trained spine surgeon and second opinion would also be reasonable at this time.

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.