

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 #: M2-06-1124-01
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 Downs Stanford, ReviewMed, Ghadially, Farzana Sahi, and Lone Star Ortho. 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 Downs Stanford:

Diagnostic Note (01/27/05)
Therapy Notes (12/15/03-07/22/04)
Return to Work Evaluation (08/11/05)
IRO review (11/16/05)

Information provided by ReviewMed:

Required Medical Evaluation (05/24/04)

Information provided by Dr. Ghadially:

Diagnostic Note (01/27/05)

Information provided by Farzana Sahi, M.D.:

Return to Work Evaluation (08/11/05)

Information provided by Information provided by Lone Star Ortho:

Diagnostic Notes (11/10/00 - 01/27/05)
Office Notes (11/30/00 - 03/21/06)
Procedure Notes (12/18/00 - 08/26/04)
Therapy Notes (02/21/03 - 06/22/04)
Medical Evaluation (02/23/01-08/11/05)
IRO review (11/16/05)

Clinical History:

This is a 48-year-old male who injured his lumbar region while operating a trencher, which got caught on a root causing it to jerk up and down while he tried to keep his hold on the equipment.

2000–2001: Initially, the patient was treated conservatively with physical therapy (PT), medications, and three transforaminal epidural steroid injections (ESIs) at the right L5 nerve root, but without any reduction in his complaints. Magnetic resonance imaging (MRI) of the lumbar spine revealed a moderate-sized right paracentral disc herniation at L1-L2. Electromyography/nerve conduction velocity (EMG/NCV) studies revealed right L5 radiculopathy. In a required medical evaluation (RME), Leslie Bishop, M.D., assessed maximum medical improvement (MMI) as of March 29, 2001, and assigned 0%

whole person impairment (WPI) rating. On April 28, 2001, H. Bryant Lee, D.C., a designated doctor, assessed MMI and assigned 7% WPI rating. Subsequently, the patient was evaluated by a neurosurgeon and an orthopedic surgeon who noted a non-dermatomal subjective numbness in the entire left leg and bilateral positive straight leg raising (SLR) tests. A lumbar discogram was ordered, which was positive for concordant pain at L4-L5. Post-discogram computerized tomography (CT) showed a congenitally borderline-to-small anteroposterior spinal canal dimensions at L3-L4 and L4-L5; irregular contrast accumulation within the posterior aspect of the L4-L5 disc possibly related to degenerative disc disease (DDD) and/or disc fissuring, associated with diffuse degenerative disc bulging at L4-L5; and degenerative facet arthropathy bilaterally at L3-L4 and L5-S1. On December 29, 2001, Maurice Conte, M.D., performed bilateral hemilaminectomy, discectomy, foraminotomy and nerve root decompression at L3-L4, L4-L5, and L5-S1; posterolateral arthrodesis and instrumentation at L4-L5 and L5-S1.

2002: Following the surgery, the patient noted the onset of right hand ulnar numbness and burning in the lateral aspect of his thighs. EMG/NCV studies revealed carpal tunnel syndrome (CTS) and C7 radiculopathy on the right. An MRI of the cervical spine revealed a posteriorly bulged disc at C2-C3 and posteriorly protruded discs at C3-C4, C4-C5 and C5-C6. The patient was treated with aquatic therapy and wrist splints. Kenneth Berliner, M.D., noted a negative SLR test, diminished sensations in the sole, and absent deep tendon reflexes (DTRs), all on the left. He diagnosed failed lumbar fusion from L3 through S1. A lumbar myelogram/post-myelogram CT scan revealed the following: (a) A 3-mm circumferential right paracentral posterior-right intra-recess herniated and extruded disc at L1-L2 with focal mass effect to the thecal sac resulting in right paracentral spinal stenosis and stenosis of the lateral recess; (b) a 3-mm diffuse posterior bulge or protruded disc at L3-L4 with marked facet arthropathies and infolding of the ligamentum flava resulting in focal severe central spinal stenosis with a hour-glass deformity of the opacified subarachnoid space; and (c) facet arthropathies with slight reduction of the lateral recesses at L4-L5 and L5-S1 with perithecal, perineural fibrosis and scars bilaterally.

Dr. Berliner assessed statutory MMI as of September 24, 2002, and assigned 16% WPI rating. A lumbar discogram/CT scan revealed a torn annulus right paracentral posteriorly at L1-L2 with severe concordant pain more towards the right with a 3 to 4 mm concentric right paracentral posterior, right intra-recess, herniated, and extruded disc migrating inferiorly with focal mild-to-moderate mass effect to the thecal sac and right-sided lateral recess causing right paracentral spinal stenosis and stenosis of the right-sided lateral recess at L1-L2; central spinal stenosis at L3-L4 due to marked hypertrophic facet arthropathies, and infolding of the ligamentum flava at L3-L4. On October 23, 2002, Kevin Moran, M.D., performed hardware removal from the posterior spine, exploration of the fusion, revision lumbar laminectomy, and additional level lumbar laminectomy. A postsurgical CT scan revealed solid fusion from L4 through S1.

2003: On May 6, 2003, Dr. Tomaszek performed laminectomy and neurolysis at L1, L2 and L3. An MRI of the lumbar spine revealed: (1) elongated fluid collection posterior to the dural sac at L4-L5 and L5-S1, possibly representing a seroma or a pseudomeningocele. (2) Decreased water content in the disc spaces at L1-L2 and L3-L4

with a small fluid collection centrally in the disc space at L3-L4. (3) Non-ferromagnetic bone cages within the disc spaces at L4-L5 and L5-S1 with the bone cages slightly flattening the dural sac at L4-L5 and extending slightly towards the left lateral recess. (4) Enhancing scar tissue at multiple levels. (5) Asymmetrical protruding disc with osteophytic ridging at L3-L4, worse on the left. Per Dr. Berliner, the patient suffered from neurogenic pain from his foraminal stenosis at the L3-L4 level bilaterally.

2004: The patient received two selective nerve root blocks bilaterally at L3-L4. The patient attended PT and a chronic pain management program (CPMP). In an FCE, the patient qualified at a light physical demand level (PDL). A work conditioning program (WCP) was recommended. EMG/NCV studies of the lower extremities revealed possible early, sensory and motor peripheral neuropathy. In an RME, Stephen Esses, M.D., stated that the patient would require treatment by a pain management team and a WCP for his chronic low back pain syndrome.

2005: A repeat CT myelogram revealed a 3-mm broad-based posterior protrusion at L1-L2 with right and posterior accentuation mildly indenting the sac; a broad-based posterior protrusion at L3-L4 mildly indenting the sac associated with bilateral facet arthrosis, central canal stenosis and bilateral foraminal narrowing; and continuous osseous bridging across the disc space at L4-L5. Sady Ribeiro, M.D., a pain consultant, noted tenderness at the facet joints from L3 through S1 bilaterally, and positive sacroiliac (SI) maneuvers. He recommended facet injections at L3-L4, L4-L5 and L5-S1 bilaterally, and bilateral SI joint injections. The injections were denied and the rationale was that the patient was post fusion and the sensory nerves to the facet joints had been ablated at the time of fusion. Dr. Berliner stated that a request was submitted for injection at L3-L4, L4-L5 and L5-S1 when those were supposed to be at L1-L2, L2-L3 and L3-L4.

2006: On February 6, 2006, the request for facet injections from L1 through L4, and SI blocks was denied. The rationale was that the patient had no definite description of facet or SI joint disease, and there was no description of physical examination findings that would indicate the presence of SI joint disease. Facet injections produced no long term benefits and appropriate treatment for the patient would be rehabilitation with active treatment. On March 21, 2006, Dr. Berliner re-evaluated the patient for a sudden increase in his back pain. He was weaned off his narcotic pain relievers. He walked with a cane and had a significant limp in his left lower extremity. An examination revealed diminished sensation along the left L5 distribution, a positive SLR test on the left, and globally weakened motor strength.

Disputed Services:

Lumbar facet injection L1-L4, bilateral sacroiliac blocks (64470, 27096)

Explanation of Findings:

Please review the above summary.

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

I recommend overturning the previous denial as the patient does appear to have adjacent level disease and more importantly at L1-L2 discs, which is severely concordant on lumbar discography. At this point, the patient may require an extended surgical intervention if these treatments fail, and the best option would be to attempt nonoperative measures prior to considering any other surgical procedures. Performing L1 through L4 facet injections does appear to be reasonable as do bilateral sacroiliac joint blocks. Should these injections, however, fail this should not be repeated. The patient is known to have significant improvement from one or many of these injections, it would be reasonable to repeat them on an every 3 to 4 month basis as long as they provide significant or sufficient relief. Failure of the injections should warrant evaluation and consideration of treatment for the patient's discogenic pain arising from L1-L2. The difficulty in this patient's case is fact that there appear to be degenerative changes at the intervening segments between L1-L2 and L4-L5, the Rostral aspect of the patient's fusion. The patient may also have persistent radicular complaints resulting from epidural fibrosis or battered nerve root syndrome resulting from the interbody fusion previously performed.

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

In patients who undergo lumbar fusion, there is an incidence of approximately 17% of adjacent level disease progression. The fact that the patient has undergone surgical intervention multiple times in the lumbar spine dating back to the initial surgery in December 2001 makes treatment of the patient's adjacent levels quite reasonable. Additionally, the patient has been noted to have an extruded disc fragment at L1-L2, which likely occurred at the incident. The treatment at this level, however, appears to have been neglected, and despite the presence of a severely concordant disc, lumbar discogram in 2002, no interbody fusion has been performed at L1-L2. Leaving a floating segment between L2-L3 and L4-L5 would be unwise, however, intervening in the form of an interbody fusion with instrumentation at L1-L2 would certainly be reasonable if continued conservative measures fail. I would certainly only pursue this option if facet injections and other nonoperative means fail to provide the patient with significant improvement. At that time, a fellowship-trained spine surgeon should be enlisted to provide further recommendations for treatment.

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.