

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

June 28, 2006

Rebecca Farless
Texas Department of Insurance
Division of Worker's Compensation
Fax: (512) 804-4871

Re: Medical Dispute Resolution
MDR Tracking #: M2-06-1431-01
DWC#: _____
Injured Employee: _____
DOI: November 19, 2002
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 Dan Eidman, M.D., and Texas Municipal League. 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 Dan Eidman, M.D.:

Office notes (1/27/2004 – 3/10/2006)
Procedure notes (3/11/1999 - 10/3/2005)
Radiodiagnostics (3/3/2004 - 8/23/2004)

Information provided by Texas Municipal League:

Office notes (1/5/2005 – 3/30/2006)
Radiodiagnostics (12/27/2004 - 3/30/2006)

Clinical History:

This is a 37-year-old white male who sustained injury to his neck and back as a result of a work-related motor vehicle accident (MVA). In 1999, Jose Kinn, M.D., performed bilateral scapular nerve blocks. (2002-2003: No medical records are available for review.) In 2004, Dan Eidman, M.D., evaluated the patient for persistent pain in the lower back and sacroiliac (SI) area. Examination showed limited range of motion (ROM) of the cervical spine, diminished brachial plexus reflex on the left and decreased sensation in the C5, C6, and C7 dermatomes on the left. Neurontin was started and therapy was continued. Computerized tomography (CT) myelogram revealed: (a) a previous anterior interbody fusion at C4-C5 (intact); (b) bilateral C7 root deformities left more than right, and probably a left foraminal disc protrusion; and (c) a congenitally small caudal theca. The patient was treated at the emergency room (ER) for acute onset neck and back pain. Initial treatment with Lortab, Bextra, Neurontin, Robaxin, and Lidoderm patches was not of much help. The patient was found to have nerve root compression at C5-C6 and C6-C7 bilaterally with some protrusion of the disc at the C6-C7 level, more pronounced on the left. George Allibone, M.D., performed facet joint injections at the C5-C6 and C6-C7 levels. John Beerbower, M.D., performed bilateral cervical facet blocks at C5-C6 and C6-C7 levels with left suprascapular nerve block. The patient underwent a two-level anterior cervical discectomy and fusion (ACDF) on June 9, 2004. Dr. Eidman prescribed Vicodin and Soma. An electromyography/nerve conduction velocity (EMG/NCV) study revealed a moderate chronic right C7 radiculopathy and moderate left C6 and C7 radiculopathies with acute and chronic features. A cervical CT myelogram revealed: (1) postop changes of anterior metallic and interbody fusion at C5-C6 and C6-C7, with posterior spondylosis and probable posterior disc protrusion with osteophyte complexes; (2) interbody fusion at C4-C5; and (3) spondylosis and posterior disc protrusion at C3-C4.

In 2005, Thomas Mims, M.D., a neurosurgeon, recommended a posterior cervical laminectomy on the left at C5-C6 and bilaterally at C6-C7 for nerve decompression. Both Dr. Mims and Dr. Eidman agreed on this. It was recommended that the patient continue physical therapy (PT). It was also noted that Dr. Eidman had performed a fusion of the C4-C5 in 1995 from an anterior approach. Dr. Beerbower performed a selective bilateral C6 and C7 nerve root sleeve blockades and regional ESIs. Dr. Mims noted that the symptoms had worsened. He recommended obtaining a new myelogram to see any additional changes.

In 2006, preauthorization for the surgery request was denied for the following reason: There had not been recent imaging studies to validate what was happening anatomically from C3-C4 through C6-C7 or even C7-T1. The myelogram CT was over two year ago. An updated imaging study and a required medical examination (RME) would be reasonable. A cervical CT myelogram revealed: (a) postsurgical changes as noted in the previous CT; (b) a 4-mm, broad-based, posterior disc protrusion at C3-C4, exerting mild mass effect over the ventral aspect of the spinal cord eccentric to the left, and moderate neuroforaminal narrowing with mild-to-moderate mass effect upon the C4 exiting nerve root, left worse than right. Dr. Mims reviewed the above study and felt the patient would do well with posterior cervical laminectomy and foraminotomy at C6-C7 bilaterally. On April 7, 2006, preauthorization for the reconsideration request was denied on the grounds that available records did not support the presence of objective signs of an acute cervical radiculopathy. A repeat EMG/NCV before the request was recommended.

Disputed Services:

Decompressive posterior cervical laminectomy bilaterally at C6-C7

Explanation of Findings:

Please refer to the above summary.

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

Uphold. Although there may be a real indication for a cervical laminectomy or laminoforaminotomy at C6-7, I agree with the previous reviewers and the preauthorization department who deny the procedure, stating there are no updated images in order to validate the requested procedure. Additionally, previous evaluation and CT myelogram has revealed no evidence of C6-C7 compression or new onset radiculopathy. A CT scan with reconstruction images, including coronal and sagittal plane, would be reasonable to assess for a previous pseudoarthrosis as a potential source of the patient's continuing symptoms. Additionally, x-rays of the cervical spine in an upright posture as well as flexion and extension views would be reasonable and laboratory data to rule out infection, CBC, CRP and ESR. I would also recommend updated EMG and nerve conduction studies, but would not based my decision only on the electrodiagnostic studies, but more on the physical findings and complaints and finally an MRI of the cervical spine with its suppression of the metallic implant artifact would be reasonable and likely provide sufficient images despite the presence of a plane anteriorly.

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

It does not appear the patient currently is complaining of a definable radiculopathy. One has not been elucidated recently and the CT myelogram performed does not state there is any significant compression on any of the nearby neural structures. Electrodiagnostic studies and physical findings do not appear to correlate and would, therefore, recommend the patient's physical findings completely correlate with any pathology prior to performing a surgical procedure. Although the procedure may be reasonable, a more thorough evaluation appears to be indicated, including reconstructive images of the cervical spine, CT scan, MRI and electrodiagnostic studies.

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.