MATUTECH, INC.

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March 10, 2006

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

Re: Medical Dispute Resolution

MDR Tracking #:	M2-06-0858-01
DWC#:	___
Injured Employee:	___
DOI:	___
IRO#:	IRO5317

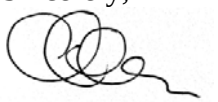
Dear Ms. Farless:

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 Steven C. Anagnost, M.D and Downs-Stanford, PC. 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 Steven Anagnost, M.D.:

Radiodiagnostic studies (03/28/00 – 11/25/05)
Office visits (03/21/00 to 01/20/06)
Therapy notes (03/21/00-07/13/05)
Procedure notes (10/23/04)

Information provided by Downs-Stanford, PC:

Peer Reviews (03/23/04-01/07/05)
Independent Medical Evaluation (10/12/04)

Clinical History:

This 36-year-old male patient injured his lower back on ___, while throwing some 100-foot lines. When the line dropped, he went forward and pulled his back out. He developed pain in his lower back going down the legs

PRE-INJURY RECORDS: In February 2000, the patient had been beat up and had developed lower back pain. He had multiple visits to a Community Comprehensive Care in California, where he was treated with chiropractic manipulative therapy (CMT) and medications. X-rays revealed probable chronic mild compression deformity at T11, mild end-plate degenerative changes at T11-T12, and mild calcification of the intervertebral disc at T10-T11. Computerized tomography (CT) revealed mild posterior disc bulging at L3-L4, L4-L5, and L5-S1, and a small calcific spur projecting into the L3-L4 disc. Patient had two falling episodes in 2003 and had increasing lower back pain. Repeat CT showed subtle disc bulges at L4-L5 and L5-S1 (unchanged from previous study). The patient also suffered from chronic anxiety with panic attacks.

POST INJURY RECORDS:

2004: Jose Reyes, Jr., M.D., a pain consultant, diagnosed lumbar radiculopathy and lumbar herniated nucleus pulposus, and prescribed Norco, Soma, and Vioxx. The patient continued physical therapy (PT). In April, the patient slipped on a wet floor with a split on his back. Magnetic resonance imaging (MRI) of the lumbar spine revealed a central disc herniation at L4-L5.

In a chiropractic peer review, Mike O'Kelley, D.C. opined: (1) The extent of the injury was to the lumbar spine. (2) There was a causal relationship between the current condition and the injury. (3) There was no objective rationale for ongoing chiropractic

care. Based on the MRI, David Berns, M.D., concluded that the mild degenerative disc disease (DDD) at L4-L5 had probably occurred over the course of many years and was not related to a single event. On October 12, 2004, James Hood, M.D., assessed maximum medical improvement (MMI), and assigned 0% whole person impairment (WPI) rating. He opined that the ongoing treatment was not related to the injury in question and the patient showed symptom magnification and inappropriate pain behaviors. The patient underwent trials of epidural steroid injections (ESIs) followed by 5 sessions of PT. In a peer review, Dr. O'Kelley opined: (1) Mr. ___ had sustained not more than a lumbar strain which had resolved. (2) The length and frequency of care had been excessive and protracted. (3) He would not need additional treatment or diagnostic testings.

2005: Steven Anagnost, M.D., an orthopedic surgeon, diagnosed traumatic lumbar spondylosis with instability and recommended the use of a sturdier brace. He refilled lidocaine patches, hydrocodone, and Ultracet. MRI of the lumbar spine revealed early disc desiccation at L4-L5. The patient attended eight sessions of PT. Dr. Anagnost recommended lumbar ESIs which were not authorized. Due to failure to conservative therapy, Dr. Anagnost recommended a lumbar interbody posterolateral fusion with stabilization at L4-L5. Allan Fielding, M.D., stated that the ongoing complaints were out of proportion to the MRI findings and the complaints suggested a symptom magnification. He recommended tapering off the narcotics.

In August, a request for the surgery was denied since the patient had no neurological findings and there were no other studies to firmly establish the pain generator as the L4-L5 level. A repeat MRI scan of the lumbar spine revealed disc desiccation and moderate facet arthropathy at L4-L5 and mild posterior bulging and mild facet arthropathy at L5-S1. Dr. Anagnost believed the patient would require a fusion and stabilization at L4-L5. In December, the 3-day inpatient stay for lumbar laminectomy at L4-L5 with posterior interbody fusion was non-authorized. This was based on the imaging study that showed only degeneration at L4-L5 and L5-S1 without instability and there were no documented objective neurological findings.

2006: On January 20, 2006, Dr. Anagnost noted worsening back pain and persistent intermittent right leg weakness and numbness. He was worried about the use of long-term narcotics. Range of motion of the lumbar spine was painful and there was numbness in the lateral calf at the L4-L5 distribution. Dr. Anagnost was awaiting authorization for the fusion and stabilization surgery since it could reduce the narcotics and improve the neurological function.

Disputed Services:

Lumbar laminectomy with foraminotomy and facetectomy at L4-L5 and posterior interbody fusion and posterior stabilization with instrumentation and posterior iliac crest bone graft.

Explanation of Findings:

As noted above, Mr. ___ had a preexisting diagnosis of lumbar spondylosis from L3 through to S1 with evidence of desiccation of the disc at each level. There is a question of a new or acute disc herniation in ___ as a result of the injury in ___. The patient, however, did not appear to have been sent for electrophysiologic studies nor preoperative discography. The patient has been submitted for potential L4-L5 posterior interbody fusion, posterior stabilization with instrumentation, posterior iliac crest graft, and lumbar decompression. MRI of the lumbar spine was repeated on several occasions revealing facet arthropathy at L5-S1 and L4-L5 with disc desiccation and bulging at those levels as well.

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

At this time it does not appear that the patient is a candidate for an isolated L4-L5 interbody fusion or decompression. The patient clearly has degenerative changes of L3-L4 and L5-S1, and an isolated fusion of the L4-L5 segment would certainly lead to progressive adjacent level of degeneration and a likely failed lumbar fusion. The patient has also not been sent for electrophysiologic studies which I would certainly recommend nor preoperative discography which would be ideal in assessing the patient's pain generator isolated to the L4-L5 level. Even using the lumbar discography to justify performing fusion at L4-L5 should it be the only concordant segment, the adjacent levels are significantly degenerated and will likely continually progress in their symptom magnitude resulting in a failed fusion.

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

In patients with adjacent level of degeneration, stopping a fusion at those segments tends to lead to transitional syndrome of a more progressive nature than is typically found in patients with normal adjacent-level discs after fusion procedures. There is between a 17 and 32% rate of adjacent-level phenomenon which will likely occur without doubt in Mr. ___'s situation secondary to the significant changes at L3-L4 and L5-S1. Also, it does not appear that the patient has been clearly defined to have a pain generator isolated to the L4-L5 level as a preoperative provocative lumbar discography with pressure monitoring has not been performed. The patient has also not been seen for electrophysiologic studies to determine the presence of a clinically definable neurologic dysfunction. I feel at the very least the patient should be sent for electrophysiologic studies and provocative discography and would still be somewhat hesitant to perform interbody fusion based on the lumbar discography as three levels are involved with a degenerative process. However, the decision to perform a decompression for any radiculopathy may be reasonable if the patient was able to obtain significant pain relief of his lower extremity symptoms with the previously performed epidural steroid injections.

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.