

MATUTECH, INC.

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July 6, 2006

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

Re: Medical Dispute Resolution
MDR Tracking #: M2-06-1339-01
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 Woodlands Sports Medicine Center. 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 Woodlands Sports Medicine Center:

Clinic notes (01/31/2005 - 03/13/2006)
Procedure note (12/02/2005 - 02/10/2006)
Therapy notes (02/21/2005 - 07/26/2005)
Radiodiagnostic (06/28/2005)

Clinical History:

This is a 39-year-old male who injured his low back while pulling a patient out of the ambulance. He felt a "pop and a twinge" on the left side of the lower back. Mariellen Barker, M.D., evaluated the patient for low back pain radiating into the left buttock and thigh, associated with numbness and tingling. There was early thoracic kyphosis. There was tenderness in the lumbosacral paraspinals and the left sacroiliac (SI) joint. The patient was taking hydrocodone, ibuprofen, and orphenadrine. Radiographs showed moderate disc space narrowing at L5-S1. Dr. Barker diagnosed L5-S1 herniated nucleus pulposus (HNP). She prescribed Medrol Dosepak, Prevacid, and Aleve. From February through July, the patient attended seven sessions of physical therapy (PT). Miguel Jocoson, M.D., performed a required medical evaluation (RME). He rendered the following opinions: (1) The diagnosis was acute lumbosacral strain, rule out lumbar disc herniation, L5-S1 with possible compression of the left spinal nerve root. (2) Obtaining a lumbar MRI study was essential to confirm the presence of a significant disc herniation. (3) Additional treatment ranging from ESIs, PT, medications, or surgical decompression might be required. MRI of the lumbar spine revealed early desiccation of the L2-L3 and L5-S1 discs, and a small tear in the posterior annulus of the L5-S1 disc. Dr. Barker recommended another course of Medrol Dosepak. Norco and Aleve were prescribed. The patient completed a course of PT. David Strausser, M.D., a pain management physician, performed a caudal epidural steroid injection (ESI). However, due to minimal improvement, Dr. Strausser decided to try one more ESI and if there was no improvement, then a consideration could be given to a lumbar CT discogram for considering possible surgical treatment.

2006: Dr. Strausser performed the second caudal ESI. Since there was a poor response to the injection, Dr. Strausser decided against the third ESI. His diagnoses were annular tear/protrusion of L5-S1 with left-sided low back pain, and left hip and thigh pain. He recommended proceeding with the lumbar CT discogram to assess the pain generator. In March, the carrier denied the lumbar CT discogram for the reason as follows: There was no evidence to support that discography was useful to promote better treatment outcomes in patients with acute low back problems. On April 11, 2006, reconsideration request for lumbar CT discogram was denied for the reason as follows: MRI showed a small tear in the posterior annulus at L5-S1 and it showed very minimal findings. There did not

appear to be evidence of radiculopathy on examination. On April 14, 2006, Dr. Strausser stated he would not consider surgery if the discogram was not performed. He decided to send the patient to a pain management physician for refills of narcotics.

Disputed Services:

Lumbar CT/Discogram at L3-L4, L4-L5, and L5-S1 (62290).

Explanation of Findings:

Please refer to the above summary.

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

My conclusion is that the denial should be overturned. I commend Dr. Strausser for his decision to not perform surgery on a patient without lumbar discography for clear internal disc derangement/discogenic low back pain. Although discography has been noted to be controversial in the past and there are several critics of this procedure, lumbar discography has progressed significantly since the mid 1990's when the belief was held that lumbar spine surgery should not be performed for back pain. In the past, discography was performed in a much more archaic manner in which pressure monitoring was not used. Multiple authors have, therefore, suggested that false positive results can lead to failed surgical procedures and poor surgical decision making. This belief in the past was the result of pressure monitoring not being performed and the ability to cause a normal disc to have concordant pain under a significant amount of pressure. Therefore, more recent studies by Derby et al and multiple journals, including the pain clinic or pain medicine journals and the Spine as well as O'Neill et al specifically in October of 2004, have revisited lumbar discography performed with pressure controlled monitoring to determine if it was possible to have more reliable outcomes and to decrease the percentages of false positive results. These authors have found that with the use of pressure controlled monitoring in the lumbar spine, using parameters such as 25 psi differentials or less to determine a truly concordant level in addition to the morphologic abnormalities on post discography imaging studies, that false positive results can actually be decreased to less than 10%. These authors and many other academicians, who believe in lumbar discography at this time, feel that lumbar discography certainly has a place in deciding if a patient is a candidate for an interbody fusion for a diagnosis of discogenic low back pain. Although ODG criteria and other criteria have been used to deny this treatment, it has been based on flawed philosophy and outdated procedures as well as outdated literature. Lumbar discography and spine surgery for back pain has progressed significantly since the mid 90's, as noted above, and outcomes have been noted to result in good to excellent outcomes at 87% to 93% with two level pathology in the mid 90's with one level pathology. There are even authors such as Pinto Et al who have noted that lumbar discography, when performed correctly and subsequent surgery to address this pathology at two and three levels had equal outcomes in Worker's Compensation patients. His study reported that 86% of people were able to return to work and improve functionality after an anterior posterior fusion for this diagnosis. He felt there was no significant difference in the clinical outcomes in these patients between two and three

levels with the exception of a mildly increased risk of pseudoarthrosis with three levels versus two levels. Many well respected spine surgeons in the academic arena at the top medical centers in the country such as the Mayo Clinic where I performed my fellowship continue to use lumbar discography in patients with isolated disc pathology to determine the actual pain generator. The use of discography has unfortunately been prevented by surgeons who are usually not spine fellowship trained and do not have a clear understanding of the importance of this study. There is no true 100% reliable test in medicine. Medicine is certainly an art and a science, and in order to determine the generator of pain, the lumbar discography is by far the most accurate test that we have to date to determine this. It has been shown in multiple studies that an MRI alone is unreliable in determining the pain generator. As a fellowship trained spine surgeon from the Mayo Clinic, I personally employ the use of lumbar discography with pressure monitoring, ensuring the pressure at the concordant level is less than 25 psi between opening and closing pressure to ensure a maximum reliability of my outcomes. I also have spoken with authors such as Eugene Kerry who has been a well known opponent to lumbar discography and he himself admits to using lumbar discography in patients with isolated disease. The questionable patients are those who have three levels or more involvement of the lumbar spine and it is clear that these patients are not as obvious a candidate for lumbar discography. It should also be noted that lumbar discography should be used only in the case in which a patient has been deemed a surgical candidate with a primary component of axial pain/low back pain resulting despite failed conservative measures for a minimum of six months or greater. I whole heartily agree with Dr. Strausser's recommendation for lumbar discography and would myself not perform a surgery on a patient with axial pain for the same diagnosis unless I was able to perform a lumbar discography which gave me some guidance before performing the operation. A lumbar discography should be allowed. The disc injection should be monitored for opening and closing pressures and the guidelines based on O'Neill's study in October of 2004 and the Spine journal should be used to ensure the disc is truly concordant. As suggested in Dr. Strausser's request, the level of involvement as well as the adjacent level should be tested to a normal control. Therefore, the use of lumbar discography to evaluate L3-4, 4-5 and 5-1 is clearly indicated and, in my opinion, necessary to determine the proper procedure for Mr. ____ from a surgical standpoint.

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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