MATUTECH, INC.

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July 24, 2006

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

Re: Medical Dispute Resolution

MDR Tracking #:	M2-06-1663-01
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 Frederick Todd, II, M.D. and Liberty Mutual. 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 neurosurgery 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 Frederick Todd, II, M.D.:

Office notes (05/24/05-06/19/06)
Radiodiagnostic studies (03/22/06-05/09/06)
Procedure notes (08/03/05-08/24/05)

Information provided by Liberty Mutual:

Radiodiagnostic studies (03/22/06-05/09/06)
Office notes (04/05/06-5/22/06)

Clinical History:

This is a 50-year-old male who injured his neck and back when he fell off a ladder landing on his left side. (No medical records are available from 2001 through 2004).

On May, 24, 2005, Alan Hurschman, M.D., a pain specialist, evaluated the patient for neck and low back pain radiating down to the left arm and left leg respectively. He noted the following: The patient was treated with chiropractic adjustments, physical therapy (PT) including McKenzie exercises, and pain medications. Magnetic resonance imaging (MRI) of the lumbar spine revealed disc protrusions at L4-L5 and L5-S1. MRI of the cervical spine showed central to right disc protrusions at C3-C4 and C4-C5 with moderate effacement of the cerebral spinal fluid right anterior to the cord; bilateral neuroforaminal stenosis and central canal stenosis; a 3-mm diffuse broad-based central disc protrusion and possible herniation at C5-C6; and a 2-mm diffuse central to left central disc protrusion at C6-C7 with moderate bilateral neuroforaminal stenosis. Electromyography/nerve conduction velocity (EMG/NCV) study revealed left C5 and C6 radiculopathy. Dr. Hurschman diagnosed cervical and lumbar disc protrusion, left lumbar facet syndrome, and left sacroiliac (SI) joint dysfunction. He prescribed Darvocet-N, Robaxin, Ambien, lorazepam, and Cymbalta. Dr. Hurschman administered trigger point injections (TPIs) into the left trapezius on multiple occasions, lumbar epidural steroid injections (ESIs) on three occasions, and cervical ESIs at C5-C6 on two occasions. A multidisciplinary chronic pain management program (CPMP) was suggested in a pain management evaluation.

In 2006, Dr. Hurschman noted that the patient was seeing a psychologist and the psychological services were helping him dramatically. He administered TPIs to the left trapezius and a third cervical ESI.

In March, repeat MRI of the cervical spine revealed: (a) moderate-to-large far left paracentral/posterolateral disc herniation at C6-C7 resulting in marked left C7 neural foraminal narrowing; (b) endplate spur and degenerative disc bulging at C5-C6 resulting in mild-to-moderate central spinal stenosis, moderate bilateral neural foraminal narrowing well related to the uncinate and facet hypertrophy; (c) borderline central spinal stenosis at C4-C5 related to endplate spur and a small broad-based right paracentral disc protrusion, mild right C4 neural foraminal narrowing related predominately to uncinate hypertrophy; and (d) mild paracervical lordotic reversal.

In May 2006, a cervical myelogram and computerized tomography (CT) revealed a herniated disc at C6-C7 on the left causing left lateral recess and foraminal stenosis and minimal indentation of the cervical cord to the left of midline; moderate spondylosis and diffuse posterior approximately 4 mm disc herniation at C5-C6 causing mild compression of the ventral cervical cord, moderate right lateral recess and foraminal stenosis and mild left lateral recess stenosis; and moderate sized disc herniation at C4-C5 on the right causing right lateral recess and foraminal stenosis and very subtle indentation of the ventral cervical cord to the right of midline. Frederick Todd, II, M.D., a neurosurgeon, recommended an anterior cervical discectomy and fusion (ACDF) at C5-C6 and C6-C7.

On May 26, 2006, Joseph Preston, M.D., denied two day inpatient stay with an ACDF at C5-C6. The rationale given was: The efficacy of cervical fusion for patients with chronic cervical pain without stability has not been demonstrated. If surgery was a consideration, counseling and discussion regarding likely outcomes, risks and benefits, and especially expectations was essential. On June 13, 2006, Deepak Awasthi, M.D., concurred with the ACDF plan and a two-day inpatient stay.

On June 19, 2006, Dr. Hurschman noted that the surgery had been approved. He scheduled a surgery on July 18, 2006.

Disputed Services:

Anterior cervical discectomy and fusion from C5-C6-C7 and with decompression of spinal cord and/or nerve root(s).

Explanation of Findings:

This case involves a now 50-year-old male who on ___ fell off a ladder landing on his left side. He developed neck pain with low back pain. The low back pain was treated chiropractically and with medications and has become less of a problem than his continued neck pain. The neck pain is now associated with left upper extremity pain. Orthopedic consultation has led to medications and in addition the patient has had epidural steroid injections and physical therapy for his neck discomfort and arm discomfort but without significant benefit. A cervical MRI evaluation on 3-22-2006 showed a large left-sided C6-7 disc herniation, along with significant stenosis at C5-6. In

addition to that test, a cervical CT myelogram suggested the same thing, that being significant spinal stenosis at C5-6 and a probable disc rupture causing compression of nerves on the left side at C6-7.

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

Overturn. I disagree with the denial for the proposed anterior cervical discectomy and fusion at both the C6-7 and C5-6 levels. The patient has had continued discomfort despite multiple attempts at conservative measures to deal with his trouble. He has MRI, CT myelographic findings, and physical examination findings suggesting nerve root compression compatible with surgically correctable pathology.

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

In dealing with this difficulty in the past 35 years, I have found that the proposed operative procedure is strongly indicated because it usually helps relieve pain under the circumstances described. Of course the patient has to understand fully the potential complications and lack of any guarantee that this will completely take care of his difficulties.

The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 35 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.