

January 21, 2005

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-0007-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**MAXIMUS Case #: TW04-0430**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurology and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he was injured in a motor vehicle accident. On 4/20/01 the patient underwent a CT scan of the lumbar spine. A CT scan of the lumbar spine performed on 5/2/03 indicated spinal stenosis at the L4-5 and L5-S1 level. On 3/2/04 the patient underwent a lumbar facet rhizotomy and on 5/25/04 the patient underwent a phenol neurolysis of lumbar facets at L3 through S1 bilaterally. On 4/1/04 the patient underwent a CT scan of the thoracic spine. Treatment for this patient's condition has included therapy and medications. The patient has continued complaints of pain and an EMG/NCV has been recommended for further evaluation of this patient's condition.

### Requested Services

NCV/EMG lumbar spine of left lower extremity.

Documents and/or information used by the reviewer to reach a decision:

*Documents Submitted by Requestor:*

1. CT report 4/20/01 and 4/1/04 and 5/2/03
2. Pain Clinic Notes 6/14/04 – 3/23/04 – 7/28/04
3. Operative Note 3/2/04, 5/25/04

*Documents Submitted by Respondent:*

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a male who sustained a work related injury to his back on \_\_\_\_\_. The MAXIMUS physician reviewer indicated that the patient has signs and symptoms of left L5-S1 radiculopathy with lumbar spinal stenosis. The MAXIMUS physician reviewer noted that the patient's last EMG/NCV was performed in 2001. The MAXIMUS physician reviewer also noted that the patient's back pain has improved after injections but that the patient has lateral left lower extremity pain and absent ankle reflex. The MAXIMUS physician reviewer explained that an EMG to assess denervation would affect decisions about treatment (such as injections or surgery). Therefore, the MAXIMUS physician consultant concluded that the requested NCV/EMG lumbar spine of left lower extremity is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
P.O. Box 17787  
Austin, TX 78744

Fax: 512-804-4011

**A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,  
**MAXIMUS**

State Appeals Department

cc: Texas Workers Compensation Commission

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 21st day of January 2005.

Signature of IRO Employee: \_\_\_\_\_  
External Appeals Department