

January 21, 2005

Dr. R
Attn: ____
800 W. Arbrook, Suite 150
Arlington, Texas 76015

VIA FACSIMILE
American Zurich Ins. Co.
Attn: Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0232-01
TWCC #:
Injured Employee:
Requestor: Dr. R
Respondent: American Zurich Ins. Co.
MAXIMUS Case #: TW04-0475

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 neurosurgery 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 is status post a C5-6 and C6-7 ACDF performed on 4/26/02 and had developed pseudoarthrosis. On 12/12/03 the patient underwent a C5-7 cervical fusion. A lumbar myelogram with CT scan following was performed on 7/19/04 and showed anterior spondylosis, disc narrowing, retrolisthesis, annular bulging without stenosis at L3-4 and a mild right upper lumbar scoliosis.

The patient reported that his neck symptoms have worsened after he began physical therapy. The impression for this patient includes left lumbar radiculopathy, 2mm central L4-5 disc protrusion extending into the left L4-5 neural foramen, status post C5-6 and C6-7 ACDF, status post C5-6 and C6-7 posterior cervical fusion, lumbar facet syndrome, and chronic pain syndrome. Currently the patient is being treated with oral medications. The patient has been recommended for a lumbar discogram to further evaluate his condition.

Requested Services

Lumbar discogram at the L3-4, L4-5, and L5-S1 level with post CT scan.

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

Documents Submitted by Requestor:

1. Follow Up 8/10/04 – 10/4/04
2. Myelogram report 7/19/04

Documents Submitted by Respondent:

1. Summary of Carrier's Position 10/12/04
2. Prior Authorization Requests 9/15/04 and 8/20/04

Decision

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

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 also noted that the diagnoses for this patient include left lumbar radiculopathy, 2mm central L4-5 disc protrusion extending into the left L4-5 neural foramen, status post C5-6 and C6-7 ACDF, status post C5-6 and C6-7 posterior cervical fusion, lumbar facet syndrome, and chronic pain syndrome. The MAXIMUS physician reviewer further noted that the patient is currently being treated with medications and that he has been recommended for a lumbar discogram to further evaluate his condition. The MAXIMUS physician reviewer indicated that the patient has facet disease. The MAXIMUS physician reviewer explained that facet disease is not an indicator for the requested discogram. Therefore, the MAXIMUS physician consultant concluded that the requested lumbar discogram at the L3-4, L4-5, and L5-S1 level with post CT scan is not 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