December 8, 2004

Texas Health
5445 La Sierra Drive, #204
Dallas, Texas 75231

VIA FACSIMILE
Fairmont Ins. Co.
Attn: ___

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0315-01
TWCC #:
Injured Employee:
Requestor: Texas Health
Respondent: Fairmont Ins. Co.
MAXIMUS Case #: TW04-0491

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 anesthesiology 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 36 year-old female who sustained a work related injury on ___. The patient reported that while at work she slipped in some water on the floor and fell injuring her hip and back. The patient underwent an EMG/NCV on 9/18/02 that was reported to be normal. On 9/27/02 the patient underwent an MRI of the lumbar spine that indicated minimal bulge of an annulus fibrosis of the intervertabral disc at L4-5 without significant canal compromise, an 8-9mm disc protrusion at the L5-S1 level producing canal and foraminal compromise with nerve

root compression bilaterally. The diagnosis for this patient includes displacement of intervertebral disc, site unspecified, without myelopathy. Treatment for this patient's condition has included conservative care, active rehabilitation and injection therapies. The patient has been recommended for a chronic pain management program for further treatment of her condition.

Requested Services

10 days of a chronic pain management program.

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

Documents Submitted by Requestor:

1. Letter of Medical Necessity 5/12/04
2. Initial Evaluation 6/9/03
3. SOAP Notes 8/21/02 – 8/5/03
4. Pre-Authorization Review 2/26/03
5. MRI report 9/27/02
6. EMG report 9/18/02
7. Work and Accident Clinic Daily Note 5/12/04 – 6/9/04

Documents Submitted by Respondent:

1. CPMP Request 9/2/04
2. Behavioral Medicine Testing Results 5/28/04, 7/16/04

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 36 year-old female who sustained a work related injury to her hip and back on ___. The MAXIMUS physician reviewer indicated that the diagnosis for this patient included lumbar disc derangement without myelopathy. The MAXIMUS physician reviewer noted that treatment for this patient's condition has included conservative care consisting of medical therapy, active rehabilitation, chiropractic manipulations, injection therapy and a work hardening program. The MAXIMUS chiropractor reviewer also noted that per a psychological evaluation, the patient has severe depression as a direct consequence of her chronic pain condition. The MAXIMUS physician reviewer explained that the patient has tried and failed conservative and interventional therapies and is not considered a surgical candidate. The MAXIMUS physician reviewer also explained that the patient has significant functional deficits and depression. The MAXIMUS physician reviewer further explained that the patient would benefit from participation in an integrated functional restoration program for the management of her pain and her related psychological disturbances. Therefore, the MAXIMUS physician consultant concluded that the requested 10 days of chronic pain management program 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

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 8th day of December 2004.

Signature of IRO Employee

Name