

April 25, 2005

VIA FACSIMILE
Ace American Ins. Co.
Attn: Javier Gonzalez

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0435-01
TWCC #:
Injured Employee:
Requestor:
Respondent: Ace American Ins. Co.
MAXIMUS Case #: TW04-509

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 physical medicine and rehabilitation 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 injured his abdomen, chest and back. The patient has undergone several MRI images of the lumbar spine and has been diagnosed with evidence of a herniated nucleus pulposus, and possibly some ligamentous injury. The patient has been treated by a chiropractor, has undergone physical therapy, has received pain management, and has been evaluated by an orthopedic surgeon. Epidural steroid injections have been recommended for further treatment of his condition.

Requested Services

Steroid Injections.

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

Documents Submitted by Requestor:

1. Report of Medical Evaluation 12/6/04
2. Review of Medical History & Physical Exam 12/6/04
3. Office Note 7/22/04
4. Lumbar Re-Assessment Summary 8/3/04 – 9/15/04

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 had been diagnosed with L5-S1 disc bulge and foraminal encroachment. The MAXIMUS physician reviewer noted that the patient has persistent low back pain with radiation to the right lower extremity and intermittent parasthesia. The MAXIMUS physician reviewer also noted that the patient has been treated with physical therapy, chiropractic treatment and pain management but that the patient persists with symptoms. The MAXIMUS physician reviewer explained that the requested epidural steroid injections are medically necessary and an accepted form of treatment for the relief of back and lower extremity pain related to a herniated disc. The MAXIMUS physician reviewer indicated that epidural steroid injections are an effective nonsurgical treatment option for patients with lumbar herniated nucleus pulposus and radiculopathy when conservative treatments are not effective and before surgical intervention is considered. Therefore, the MAXIMUS physician consultant concluded that the requested steroid injections are 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

Elizabeth McDonald
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 25th day of April 2005.

Signature of IRO Employee: _____
External Appeals Department