

January 11, 2005

Dr. N
4100 W. 15th Street, Suite 206
Plano, Texas 75093

VIA FACSIMILE
Texas Mutual
Attn: ____

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0441-01
TWCC #:
Injured Employee:
Requestor: Dr. N
Respondent: Texas Mutual Ins. Co.
MAXIMUS Case #: TW04-0523

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 reported that while at work he was carrying a heavy object when he began to experience pain in his lower back. An MRI of the lumbar spine was reported to have shown diffuse bulging at the L4-L5 level, facet hypertrophy and an annular fissure at the L4-L5 level. Treatment for this patient's condition has included conservative care consisting of medication, therapy, and cortisone

injection. The patient has been recommended for a lumbar discogram to further evaluate his condition for further treatment options.

Requested Services

Outpatient stay for L discogram with CT 3 level.

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

Documents Submitted by Requestor:

1. Letter of Medical Necessity 11/1/04
2. Follow Up Visit notes 11/25/03 – 12/2/04
3. Behavioral Medicine Assessment/Clinical Interview 2/18/04
4. EMG/NCV report 11/6/03

Documents Submitted by Respondent:

1. MRI report 8/22/03
2. Same as above

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 treatment for this patient's condition has included medications, therapy and cortisone injections. The MAXIMUS physician reviewer further noted that the patient has been recommended for a lumbar discogram to further evaluate his condition for further treatment options. The MAXIMUS physician reviewer explained that there is no clear-cut rationale for the proposed lumbar discogram. The MAXIMUS physician reviewer also explained that the requested discogram is not medically necessary to further treat this patient's condition. Therefore, the MAXIMUS physician consultant concluded that the requested outpatient stay for a lumbar discogram with CT 3 levels is not medically necessary for further treatment of 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 11th day of January 2005.

Signature of IRO Employee: _____
External Appeals Department