

December 29, 2004

VIA FACSIMILE

SORM

Attn: ____

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0452-01-SS

TWCC #:

Injured Employee:

Requestor:

Respondent: SORM

MAXIMUS Case #: TW04-0507

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 orthopedic surgery 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 40 year-old male who sustained a work related injury on _____. The patient reported that while at work he injured his cervical spine when he was attacked by a student. Initial treatment included physical therapy and oral medications. An MRI of the cervical spine performed on 9/24/01 revealed a central disc protrusion without extrusion at the C3-4 level, a posterior central radial annular tear with associated posterior focal central disc protrusion at the C5-6 level, and a normal spinal cord. The patient underwent a discogram on 11/6/02 that showed concordant pain at the C3-4, C4-5, and C5-6 levels. An EMG/NCV performed on 1/12/04 indicated a C5 and bilateral C6 motor radiculopathy. The diagnoses for this patient have included C6 radiculopathy, cervicgia, cervical disc annular tear, and cervical disc protrusion. An MRI of the cervical spine performed on 9/29/04 revealed disc protrusions at

the C3-4 and C5-6 level and an annular tear at the C5-6 level. An anterior cervical discectomy and fusion at the C4-5 and C5-6 level has been recommended for further treatment of this patient's condition.

Requested Services

Outpatient C4/5 and C5/6 anterior cervical discectomy and fusion.

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

Documents Submitted by Requestor:

1. Letter Re: Impairment Rating 10/25/04
2. Letter Re: Impairment Rating 12/4/04

Documents Submitted by Respondent:

1. EMG and Nerve Conduction Study Report 1/12/04
2. Discogram Report 11/6/02
3. MRI report 9/24/01
4. History and Physical 11/7/01
5. Daily Treatment Notes 12/20/01 – 11/8/02
6. MRI report 9/29/04

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 40 year-old male who sustained a work related injury to his cervical spine on _____. The MAXIMUS physician reviewer also noted that an anterior cervical discectomy and fusion at the C4-5 and C5-6 level has been recommended for further treatment of this patient's condition. The MAXIMUS physician reviewer indicated that this patient has chronic degenerative disc changes at 3 levels of the cervical spine. The MAXIMUS physician reviewer noted that the patient has continued complaints of chronic neck pain. The MAXIMUS physician reviewer also noted that the patient underwent a discogram that revealed positive findings at three levels. The MAXIMUS physician reviewer indicated that an EMG showed positive findings at the C8 level. The MAXIMUS physician reviewer explained that the procedure requested does not involve the C8 level. The MAXIMUS physician reviewer also explained that it is unlikely that a 2 level fusion of the cervical spine would successfully cure this patient's pain. The MAXIMUS physician reviewer further explained that there is no peer reviewed class I data to support treatment of this patient's condition with the proposed procedure. Therefore, the MAXIMUS physician consultant concluded that the requested outpatient C4/5 and C5/6 anterior cervical discectomy and fusion 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,

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 29th day of December 2004.

Signature of IRO Employee

Name