

January 31, 2005

Dr. Ryan N. Potter
Attn: May
5734 Spohn Drive
Corpus Christi, Texas 78414

VIA FACSIMILE
Texas Mutual
Attn: Ron Nesbitt

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0630-01
TWCC #:
Injured Employee:
Requestor: Ryan N. Potter, M.D.
Respondent: Texas Mutual
MAXIMUS Case #: TW05-0006

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 female who sustained a work related injury on _____. An MRI of the cervical spine performed on 10/31/97 revealed status post C5-6 and C6-7 discectomies with degenerative discs disease and degenerative changes of the uncovertebral joints producing neural foraminal stenosis, no evidence of cord compression, and no abnormal enhancement seen. The diagnoses for this patient have included cervical herniated/displaced disc at the C3-4, C4-5 and C6-7 levels, cervical radiculitis, and radicular pain. An MRI performed on 8/20/04

revealed that the patient was status post cervical spine surgery involving the C4, C5, C6, and C7, and a large extra dural defect right paracentral in location consistent with disc herniation, and no evidence of an abnormal signal of the spinal cord suggestive of MS. The patient has been recommended for cervical epidural steroid injections with fluoroscopic guidance and sedation.

Requested Services

CESI under fluoroscopic guidance and with sedation.

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

Documents Submitted by Requestor:

1. Letter of Medical Necessity 12/6/04
2. MRI report 8/20/04
3. Chart Notes 8/2/04 – 12/6/04
4. History & Physical 11/8/04

Documents Submitted by Respondent:

1. History and Physical/Procedure Notes and Chart Notes 12/8/03 – 11/8/04
2. MRI report 10/31/97

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 female who sustained a work related injury to her cervical and lumbar spine. The MAXIMUS physician reviewer indicated that the patient required cervical and lumbar laminectomies and continues with radiculopathies involving the cervical and lumbar spine and has been under the care of a pain management specialist. The MAXIMUS physician reviewer noted that the patient has undergone treatment with medical therapy and the use of a morphine and clonidine pump in addition to surgical intervention. The MAXIMUS physician consultant explained that the results on an MRI indicated s/p cervical spine surgery involving the C4, 5, 6 and 7 levels as well as a large extra dural defect right paracentral in location consistent with a disc herniation. The MAXIMUS physician reviewer noted that the patient has been recommended for cervical epidural steroid injection therapy for further treatment of her condition.

The MAXIMUS physician consultant indicated that the documentation provided demonstrated that the enrollee has a work related cervical disc disease with continued pain and cervical disc herniation evidenced by MRI. The MAXIMUS physician consultant noted that the diagnoses for this patient have included cervical herniated/displaced disc at the C3-4, C4-5, and C6-7 levels, cervical radiculitis and continued radicular pain. The MAXIMUS physician reviewer also noted that the patient has continued complaints of pain with continued narcotic use. Therefore, the MAXIMUS physician consultant concluded that the requested cervical epidural steroid injection

under fluoroscopic guidance and sedation 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

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 31st day of January 2005.

Signature of IRO Employee: _____
External Appeals Department