

May 16, 2005

VIA FACSIMILE
Texas Council Risk Mgt.
Attn: Heather Cody

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0729-01-SS
TWCC #:
Injured Employee:
Requestor:
Respondent: Texas Council Risk Mgt.
MAXIMUS Case #: TW05-0019

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 female who sustained a work related injury on _____. The patient reported that while at work she fell. Since the fall, the patient has experienced continued bilateral upper extremity pain, right shoulder and right knee pain. The patient has reportedly undergone right shoulder rotator cuff repair and a right medial meniscectomy repair. Following surgery the patient was treated with rehabilitative therapy. A MRI of the lumbar spine performed on 8/11/04 revealed posterior and central herniation of L5/S1, degenerative disc disease at L4/5 with posterior bulge of the disc, and desiccation of the nucleus pulposus of L3 and L4 and anterior bulge of this disc of 4mm. The patient has been recommended for a L5-S1 laminectomy w/lateral fusion and foraminectomy for further treatment of her condition.

Requested Services

L5-S1 laminectomy with lateral fusion and foraminectomy with inpatient stay times 3 days.

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

Documents Submitted by Requestor:

1. EMG/NCS report 3/17/03
2. MRI reports 12/26/00 and 8/11/04
3. Office Notes 11/10/00 – 4/20/05

Documents Submitted by Respondent:

1. No documents submitted

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 female who sustained a work related injury on _____. The MAXIMUS physician reviewer also noted that the patient has multiple levels of lumbar disc degeneration (L3-4, L4-5, L5-S1). The MAXIMUS physician reviewer explained that recent MRI findings showed degenerative spine pathology and a slight disc bulge of 4mm. The MAXIMUS physician reviewer indicated that there is no justification for a single level fusion procedure where multiple levels are involved. The MAXIMUS physician reviewer explained that fusion surgery has poor results when multiple levels are present. The MAXIMUS physician reviewer indicated that this patient has had multiple orthopedic procedures performed in the past. Therefore, the MAXIMUS physician consultant concluded that the requested L5/S1 laminectomy with lateral fusion and foraminectomy with inpatient stay times 3 days 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,

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 16th day of May 2005.

Signature of IRO Employee: _____
External Appeals Department