

March 3, 2005

VIA FACSIMILE
American Home Assurance
Attn: Raina Sims

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0779-01-SS
TWCC #:
Injured Employee:
Requestor:
Respondent: American Home Assurance
MAXIMUS Case #: TW05-0025

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 female who sustained a work related injury on _____. The patient reported that she fell from a chair injuring her lumbar and cervical spine. The initial diagnoses for this patient have included lumbar/cervical sprain/strain. Treatment for this patient's condition has included physical therapy, medications, lumbar laminectomy, transforaminal selective epidural block, spinal cord stimulator and neuromuscular stimulator. The current diagnosis for this patient includes cervical radiculopathy. The patient has been recommended for a C4-7 anterior cervical discectomy and fusion with SLIM LOK Plates & VG2 graft for further treatment of her condition.

Requested Services

Anterior cervical discectomy and fusion with SLIM LOK Plates & VG2 graft at the C4-7 levels.

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

Documents Submitted by Requestor:

1. No documents submitted

Documents Submitted by Respondent:

1. Peer Review 9/27/02
2. RME 1/9/03
3. DDE 3/28/03 and 7/20/04
4. Diagnostic Reports for spine 3/2/02, 6/3/02, 10/30/02, 6/18/03, 7/29/03, 10/30/03, and 5/5/04
5. MRI report 4/3/02, 2/6/03 and 6/8/04
6. Referrals and Consultations 3/2/02, 4/3/03, 6/3/02, 10/30/02, and 6/18/03
7. EMG/NCV report 12/16/04

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 female who sustained a work related injury to her back on _____. The MAXIMUS physician reviewer also noted that the treatment for this patient's condition has included physical therapy, medications, lumbar laminectomy, transforaminal selective epidural block, spinal cord stimulator and a neuromuscular stimulator. The MAXIMUS physician reviewer further noted that an anterior cervical discectomy and fusion with SLIM LOK Plates & VG2 graft at the C4-7 levels has been recommended for further treatment of this patient's condition. The MAXIMUS physician reviewer explained that the patient's diagnosis of cervical stenosis is not a condition treatable with surgical intervention. The MAXIMUS physician reviewer also explained that there is no clear indication for the requested surgery. Therefore, the MAXIMUS physician consultant concluded that the requested anterior cervical discectomy and fusion with SLIM LOK Plates & VG2 graft at the C4-7 levels 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 3rd day of March, 2005.

Signature of IRO Employee: _____
External Appeals Department