March 16, 2005

Dr. Robert J. Henderson
1261 Record Crossing
Dallas, TX 75235

VIA FACSIMILE
American Home Assurance
Attn: Raina Sims

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0971-01-SS
TWCC #:
Injured Employee:
Requestor: Dr. Robert J. Henderson
Respondent: American Home Assurance Co.
MAXIMUS Case #: TW05-0032

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 injured his back when he fell, carrying two pallets. The initial diagnoses for this patient included lumbar disc disorder with radicular pain, and back sprain/strain with associated myospasm. Treatment for this patient's case has included physical therapy, an ice cap collar, neuromuscular stimulator, an electric heat pad, and medications consisting of Naporxen, Flexeril, Cyclobenzaprine, Tramadol, and Hydrocodone. The current diagnoses for

this patient include probable discogenic pain L4/5 and L5/S1 levels, evoked potential evidence of right S1/S2 radiculopathy as well as right L5 and Left S1 radiculopathy, and probable facet arthropathy at bilateral L4/5.

Requested Services

Anterior interbody fusion L4/5, retroperitoneal exposure and discectomy @ L4/5, anterior interbody fusion fixation L4/5, posterior decompression L4/5, posterior internal fixation L4-S1, bone graft, allograft, in situ, bone graft, and autograft iliac crest.

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

Documents Submitted by Requestor:

1. Independent Review Organization Summary 2/22/05
2. MRI report 11/13/03
3. X-ray reports 11/3/03
4. EMG/NCV report 1/14/04
5. Treatment records 11/3/03 – 8/23/04
6. FCE report 5/26/04 and 9/14/04

Documents Submitted by Respondent:

1. Review Determination 1/6/05 and 1/17/05
2. Chart Note 12/10/04, 11/23/04
3. Lumbar Myelogram report 11/11/04
4. CT scan report 11/11/04

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 male who sustained a work related injury to his back on ___. The MAXIMUS physician reviewer also noted that the diagnoses for this patient have included lumbar disc disorder with radicular pain, back sprain/strain with associated myospasm, probable discogenic pain at L4/5 and L5/S1 levels, evoked potential evidence of right S1/S2 radiculopathy as well as right L5 and left S1 radiculopathy, and probable facet arthropathy at bilateral L4/5. The MAXIMUS physician reviewer further noted that the patient has been recommended for back surgery for further treatment of his condition. The MAXIMUS physician reviewer explained that there is no clear basis for requested surgery. The MAXIMUS physician reviewer noted that patient has minimal nerve root compressions and that there is no clear rationale proposed for requested procedure. Therefore, the MAXIMUS physician consultant concluded that the requested anterior interbody fusion L4/5, retroperitoneal exposure and discectomy @ L4/5, anterior interbody fusion fixation L4/5, posterior decompression L4/5, posterior internal fixation L4-S1, bone graft, allograft, in

situ, bone graft, and autograft iliac crest 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 March 2005.

Signature of IRO Employee: _____
External Appeals Department