

April 12, 2005

VIA FACSIMILE  
Dr. Robert J. Henderson  
Attn: Amanda S.

VIA FACSIMILE  
SORM  
Attn: Natrisha Bates

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-1066-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Robert J. Henderson, MD**  
**Respondent: SORM**  
**MAXIMUS Case #: TW05-0056**

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 44 year-old female who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work she injured her back. An MRI of the lumbar spine performed on 12/31/01 showed a 1-2mm posterior annular bulge at L4/5 with mild narrowing of the exti neuroforamen bilaterally, a 2-3mm central hyperintense protrusion at L5/S1 with disc desiccation, and mild facet arthropathy at L5S1 bilaterally. A discogram performed on 3/19/02 revealed normal disc in all respects at L3/4 and L4/5, and a fissured disc with severe concordant pain reproduced at L5/S1. On 8/9/02 the patient underwent a transforaminal

interbody fusion at the L5/S1 level with bilateral transverse process fusions and internal fixation, segmental pedicle at L5/S1 bilaterally. Electrodiagnostics performed on 11/11/03 showed evidence of left S1 radiculopathy and right L5 radiculopathy. Myelo/CT performed on 1/10/03 showed no significant abnormalities other than post surgical changes at L5/S1 and an MRI performed on 6/28/04 was interpreted as normal. The patient has been recommended for a hardware block to further evaluate her condition.

### Requested Services

Outpatient L5/S1 hardware block.

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

#### *Documents Submitted by Requestor:*

1. MRI report 12/31/01
2. Chart Note 11/23/04

#### *Documents Submitted by Respondent:*

1. Daily Team Meeting and Therapeutic Exercises Progress Notes 11/30/01 – 1/4/02
2. Established Patient Visit 10/30/01
3. Operative Note 8/9/02
4. Daily Progress Notes 5/14/02 – 12/19/02
5. Office Notes 5/2/02 – 4/10/03

### 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 on 8/9/02 the patient underwent a transaminial interbody fusion at the L5/S1 level with bilateral transverse process fusions and internal fixation, segmental pedicle at L5/S1 bilaterally. The MAXIMUS physician reviewer further noted that outpatient L5/S1 hardware blocks have been requested for further treatment of this patient's condition. The MAXIMUS physician reviewer indicated that this patient experiences postoperative back pain. The MAXIMUS physician reviewer explained there is no medical justification for performing a hardware block for this patient's condition. The MAXIMUS physician reviewer indicated that there is no literature to support the efficacy of hardware blocks for treatment of this patient's condition. Therefore, the MAXIMUS physician consultant concluded that the requested outpatient L5/S1 hardware block 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 12th day of April 2005.

Signature of IRO Employee: \_\_\_\_\_  
External Appeals Department