

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:****SOAH DOCKET NO. 453-05-6734.M2**

May 6, 2005

VIA FACSIMILE  
Dr. Frank J. Garcia  
Attn: Sally TorrezVIA FACSIMILE  
Liberty Mutual Fire Insurance  
Attn: Virginia Cullipher**NOTICE OF INDEPENDENT REVIEW DECISION****RE: MDR Tracking #: M2-05-1362-01  
TWCC #:  
Injured Employee:  
Requestor: Dr. Frank J. Garcia  
Respondent: Liberty Mutual Fire Insurance  
MAXIMUS Case #: TW05-0078**

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 male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he injured his cervical spine and bilateral shoulders when he fell. Initial

treatment consisted of conservative measures and he was subsequently referred for an orthopedic surgery consultation. An MRI of the cervical spine performed on 4/17/01 was reported to have shown disc protrusion at C5-6 and a MRI of the right shoulder was reported to have shown acromioclavicular joint arthritis and mild tendonitis. On 6/2/02 the patient underwent right shoulder rotator cuff repair followed by physical therapy. On 9/16/02 the patient underwent a cervical discectomy and fusion at C5-6 and C6-7. The patient underwent a left shoulder arthroscopic acromioplasty with distal clavicular resection on 2/23/04. A repeat MRI of the cervical spine was reported to have shown evidence of a bony prominence at C5-6 and C6-7. The patient has continued complaints of pain in the middle of his back, buttocks, between his shoulder blades, left knee, left arm and hand, and left foot. He has been recommended for a discogram to diagnose his condition for further treatment.

### Requested Services

Discogram.

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

#### *Documents Submitted by Requestor:*

1. Office Note 3/2/04 - 1/11/05
2. Required Medical Examination 1/14/05
3. Operative Note 9/16/02
4. MRI report 9/24/04

#### *Documents Submitted by Respondent:*

1. Position Statement 3/24/05
2. Pre Authorization 12/27/04
3. Appeal 2/24/05
4. MRI report 9/24/05
5. FCE 3/24/04

### 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 cervical spine and bilateral shoulders on \_\_\_\_\_. The MAXIMUS physician reviewer also noted that the patient has undergone shoulder surgery and a cervical discectomy and fusion at the C5-6 and C6-7 levels. The MAXIMUS physician reviewer further noted that the patient has continued complaints of pain and that the patient has been recommended for a discogram. The MAXIMUS physician reviewer noted that the patient had undergone a discogram for low back and buttock pain in 2004. The MAXIMUS physician reviewer indicated that a cervical spine discogram is indicated when there are neurological changes noted or if revision surgery is being considered. Therefore, the MAXIMUS physician consultant concluded

that the requested discogram 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  
Mr. \_\_\_\_

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 6th day of May 2005.

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