

June 8, 2005

VIA FACSIMILE
Assoc. Casualty Ins. Co.
Attn: Robert Josey

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-1668-01
TWCC #:
Injured Employee:
Requestor:
Respondent: Assoc. Casualty Ins. Co.
MAXIMUS Case #: TW05-0102

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 back. The diagnoses for this patient include low back pain, lumbar spinal stenosis, and lumbar radiculopathy. On 8/1/96 the patient underwent discography and chemonucleolysis for the preoperative diagnoses of degenerative disc disease L3-L5 with herniated nucleus pulposus, L4-5 and left S1 radiculopathy and right L5 radicular symptoms. Additional treatment has included medications. The patient has reported constant low back pain extending into his bilateral lower extremities. A dorsal column stimulator has been recommended for further treatment of his condition.

Requested Services

Dorsal Column Stimulator trial.

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. History and Physical 2/22/05
2. Psychological Evaluation 2/15/05
3. Operative Note 8/1/96

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 include low back pain, lumbar spinal stenosis, and lumbar radiculopathy. The MAXIMUS physician reviewer further noted that the patient underwent discography and chemonucleolysis for the preoperative diagnoses of degenerative disc disease L3-L5 with herniated nucleus pulposus, L4-5 and left S1 radiculopathy and right L5 radicular symptoms and that the patient has also been treated with medications. The MAXIMUS physician reviewer indicated that a trial use of a dorsal column stimulator has been requested for further treatment of his condition. The MAXIMUS physician reviewer explained that there is no class I data to support the treatment of degenerative disc disease and back pain with a dorsal column stimulator. The MAXIMUS physician reviewer also explained that the efficacy of a dorsal column stimulator in the treatment of this patient's condition has not been proven. Therefore, the MAXIMUS physician consultant concluded that the requested dorsal column stimulator trial 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 8th day of June 2005.

Signature of IRO Employee: _____
External Appeals Department