

June 30, 2005

VIA FACSIMILE
John A. Sazy, MD
Attn: Kristi Songer

VIA FACSIMILE
Westport Insurance Corp/Gallagher Bassett
Attn: Diana

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-1800-01
TWCC #: _____
Injured Employee: _____
Requestor: John A. Sazy, MD
Respondent: Westport Insurance Corp/Gallagher Bassett
MAXIMUS Case #: TW05-0125

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 neurology 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 26-year old male who sustained a work related injury to his back on _____. The patient reported that he injured his neck and back in a motor vehicle accident while at work. He reported he experienced stabbing, burning, aching, tingling, and throbbing pain down both legs. The diagnoses for this patient include lumbar/cervical sprain/strain, acute and chronic post-traumatic headache, previous T11-L1 fusion with resultant 30% wedge deformity of T12, disc protrusion at L4-5 with impingement of foraminal L4-5 root sleeve, an 2-3 mm paracentral disc protrusion T9-10. Treatment has included medications, epidural steroid

injections, physical therapy and chiropractic manipulations. Lumbar discogram was recommended.

Requested Services

Lumbar Discogram

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

Documents Submitted by Requestor:

1. Office Visits – 4/14/05, 12/23/04, 11/4/04
2. Lumbar Myelogram & CT – 11/29/04
3. MRI – 8/11/04
4. Electrophysiological testing – 12/13/04
5. American Orthopaedic & Neurological Rehabilitation Centers Progress Note -12/3/04, 12/13/04
6. Pain Management procedure notes - 11/5/04, 10/22/04

Documents Submitted by Respondent:

1. Statement of Medical Necessity - 5/3/05
2. Report of Medical Evaluation – 4/7/05
3. Lumbar Myelogram & CT – 11/29/04
4. Neurosurgery Evaluation – 10/19/04
5. Office Visits – 4/14/05, 12/23/04, 11/4/04
6. American Orthopaedic & Neurological Rehabilitation Centers Progress Note - 12/3/04, 12/13/04
7. CT – 10/22/04
8. Pain Management follow-up – 4/5/05, 3/8/05, 2/18/05, 1/28/05, 1/7/05, 12/21/04, 10/29/04,
9. Pain Management procedure notes - 11/5/04, 10/22/04
10. History & Physical - 9/28/04
11. Back Evaluation - 3/20/05
12. Physical Therapy Notes - 3/2/05-4/1/05
13. Cervical Evaluation – 2/28/05
14. Chiropractic Clinic Notes - 8/6/04 -4/22/05

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this patient had a lumbar sacral injury in a motor vehicle accident. The MAXIMUS physician reviewer noted he continues to have low back pain and left lower extremity symptoms. The MAXIMUS physician reviewer further noted an EMG was negative but few muscles were studied. The MAXIMUS physician reviewer explained MRI and CT scans showed left foraminal herniated nucleus pulposus at L4L5 with root involvement. The MAXIMUS physician reviewer also explained he failed physical therapy,

chiropractic, oxycontin and epidural steroid injections. The MAXIMUS physician reviewer indicated that discography is an accepted, and supported modality in decision making for lumbar sacral surgery or fusion. Therefore, the MAXIMUS physician consultant concluded that the requested lumbar discogram is medically necessary for evaluation and treatment of the 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

Lisa Gebbie, MS, RN
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 30th day of June 2005.

Signature of IRO Employee: _____
External Appeals Department