

June 21, 2005

VIA FACSIMILE  
Jacob Rosenstein, MD  
Attn: Cheryl

VIA FACSIMILE  
Ace American Insurance  
Attn: Albert Ayala

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-1840-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Jacob Rosenstein, MD**  
**Respondent: Ace American Insurance c/o Broadspire**  
**MAXIMUS Case #: TW05-0120**

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 male who sustained a work related injury to his back on \_\_\_\_\_. The patient reported injuring his neck while working on a derrick when he slipped and bumped the right side of his hard hat while pulling a water hose. He developed increasing pain in the right side of his neck, shoulder and scapular area. The diagnoses for this patient include traumatic cervical strain, possible C7 radiculopathy, left ulnar entrapment neuropathy, and traumatic left shoulder injury and rotator cuff tear. He has been treated with multiple spine and shoulder surgeries,

physical therapy, medication, and cervical epidural injections. Cervical epidural injections have been recommended for treatment of his condition.

#### Requested Services

Cervical epidural steroid injections.

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

##### *Documents Submitted by Requestor:*

1. Medical conference note & follow-up notes 4/6/05, 4/19/05
2. Preauthorization Determination 2/24/05, 4/20/05

##### *Documents Submitted by Respondent:*

1. Retrospective review of medical records by neurologist 12/1/03, 12/5/03

#### 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 is status post three surgeries of the cervical spine with persistent symptoms. The MAXIMUS physician reviewer noted that he last had cervical epidural steroid injection in 2001. The MAXIMUS physician reviewer further noted he has had two surgeries since that time. The MAXIMUS physician reviewer explained that the patient has few options for treatment. The MAXIMUS physician reviewer also explained that a limited trial of two to three services epidural steroid injections may be beneficial and has limited risk associated with the procedure. Therefore, the MAXIMUS physician consultant concluded that the requested cervical epidural steroid injections are medically necessary for 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 21th day of June 2005.

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