

July 7, 2005

VIA FACSIMILE  
Ward North America  
Attention: Roberta Cole

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-1964-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent: Ward North America**  
**MAXIMUS Case #: TW05-0130**

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 to his back and leg on \_\_\_\_\_. The patient reported that while transporting a patient in an ambulance as a paramedic, he fell when the vehicle braked quickly. An MRI of the spine showed a shallow central disc protrusion and an annular tear at L5-S1 that was in contact with, but not displacing the S1 nerve roots bilaterally. A bone scan of the knees showed no abnormal uptake in the knees and increased uptake in the soft tissue of the calf that was of uncertain clinical significance. The diagnoses for this patient include lumbar disc displacement, lumbar sprain, and medial collateral ligament sprain. He has been treated with physical therapy, a work hardening program, medication, and epidural blocks. Posterior lumbar fusion with instrumentation has been recommended for treatment of his condition.

## Requested Services

Posterior lumbar fusion with instrumentation

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

### *Documents Submitted by Requestor:*

None

### *Documents Submitted by Respondent:*

1. Orthopaedic Evaluation - 7/1/04
2. Physical therapy records – 7/7/04-2/18/05
3. Orthopaedic Clinic Notes – 7/14/04-4/11/05
4. MRI – 9/10/04
5. X-ray – 12/3/04
6. Hospital records - 12/3/04
7. Operative report – 12/13/04, 1/3/05
8. EMG/NCV Study – 1/3/05

## Decision

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

## Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this patient has multi-level lumbar degeneration as evidenced on MRI (9/10/04). The MAXIMUS physician reviewer also noted results of fusion surgery on patients who have multi-level disease are poor. The MAXIMUS physician reviewer further noted this patient has facet arthrodesis at levels 3-4, L4-5, and L5-S1. The MAXIMUS physician reviewer indicated literature does not support fusion surgery on patients who have multi-level disease, as in this patient's situation as the chances of success are very low. (Bradwell, Textbook of Spinal Surgery, Chapter on Lumbar Degeneration/Fusion. Lippencott Publishing.)

Therefore, the MAXIMUS physician consultant concluded that the requested posterior lumbar fusion with instrumentation procedure 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**

Lisa Gebbie, MS, RN  
State Appeals

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 7th day of July 2005.

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