September 1, 2005

VIA FACSIMILE
Liberty Mutual Fire Insurance
Attn: Carolyn Guard

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-2247-01
TWCC #:
Injured Employee:
Requestor:
Respondent: Liberty Mutual Fire Insurance
MAXIMUS Case #: TW05-0176

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 physical medicine and rehabilitation 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 41-year old male who sustained a work related injury on ___. He underwent a history of posterior lumbar interbody fusion (PLIF) with cages and pedicle screws in 1997. The instrumentation was removed in 1998. He was then treated for chronic pain and a spinal cord stimulator was implanted on 8/9/02. He continues with moderate to severe low back pain. Diagnoses include clumping of the left L5 nerve root in the dura suggesting arachnoiditis on myelogram, lumbar radiculopathy and thoracic pain. Treatment has included a spinal cord stimulator, surgery, bilateral lumbar facet injections and OxyContin.

Requested Services

Request for purchase of an adjustable bed.

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

Documents Submitted by Requestor:

1. Letter of medical necessity – 4/19/05
2. Neurology follow-up – 4/15/05

Documents Submitted by Respondent:

1. Letter of medical necessity – 4/19/05
2. Peer Review Analysis – 4/20/05

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician consultant explained that this 41-year old male has chronic back pain, failed back syndrome, and is status post L5-S1 posterior lumbar interbody fusion, status post removal of hardware and status post spinal cord stimulator implant. The MAXIMUS physician consultant indicated he has bilateral bilateral facet syndrome and chronic L5 arachnoiditits. The MAXIMUS physician consultant noted that a neurosurgery office visit note makes no mention that an adjustable bed was needed. The MAXIMUS physician consultant also noted that a letter of medical necessity dated 4/19/05 reported that an adjustable bed had been recommended and was medically necessary for his condition. The MAXIMUS physician consultant explained there was no explanation describing why the adjustable was necessary. The MAXIMUS physician consultant also noted that generally an electric hospital bed is considered medically necessary if the patient requires frequent changes of position to alleviate pain and is unable to accomplish this on a regular bed. The MAXIMUS physician consultant indicated that there is no documentation that this member requires an adjustable bed for treatment of his condition.

Therefore, the MAXIMUS physician consultant concluded that the requested purchase of an adjustable bed is not medically necessary for treatment of this patient's condition.

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 1st day of September 2005.

Signature of IRO Employee: _____
External Appeals Department