

September 2, 2005

VIA FACSIMILE
Jacob Rosenstein, MD
Attn: Jennifer

VIA FACSIMILE
Zurich American Insurance Company/F.O.L.
Attn: Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-2256-01
TWCC #:
Injured Employee:
Requestor: Jacob Rosenstein, MD
Respondent: Zurich American Insurance Company/F.O.L.
MAXIMUS Case #: TW05-0179

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 neurosurgery 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 48-year old female who sustained a work related injury on _____. The patient reported that while assisting a patient up in bed, she had low back pain. She also reported a constant ache that becomes severe at times. She also reported radiating pain to the left and right buttocks and tingling in the left leg to her heel. Diagnoses included strained back, and mild disc bulges at L4-5 and L5-S1. Treatment has included chiropractic adjustments, electrical stimulation, cold pack, oral medications, and physical therapy. A lumbar epidural steroid injection has been recommended for treatment of her condition.

Requested Services

Preauthorization request for outpatient lumbar epidural steroid injection.

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

Documents Submitted by Requestor:

1. Jacob Rosenstein, MD Records – 6/29/05, 9/19/05
2. MRI Report – 6/7/05

Documents Submitted by Respondent:

1. Notice of Utilization Review Findings – 7/19/05, 7/26/05
2. Jacob Rosenstein, MD Records – 6/29/05, 9/19/05
3. Summary of Carrier's Position – 8/15/05
4. MRI Report – 6/7/05
5. Coleman Chiropractic and Acupuncture Records - 5/25/05-6/23/05
6. Orthopedic Notes – 5/24/05
7. Baylor Medical Center at Irving Records – 5/17/05
8. Healthsouth Evaluation Center Medical Evaluation – 7/20/05

Decision

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

Rationale/Basis for Decision

MAXIMUS CHDR physician consultant indicated that this patient has not had an adequate trial of physical therapy. MAXIMUS CHDR physician consultant noted there is no documentation of neural compression. MAXIMUS CHDR physician consultant explained there is no role for epidural steroid injections in this patient. MAXIMUS CHDR physician consultant concluded that the requested epidural steroid injection is not medically necessary for treatment of this patient's condition at this time.

Therefore, the MAXIMUS physician consultant concluded that the requested outpatient lumbar epidural steroid injection 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 2nd day of September 2005.

Signature of IRO Employee: _____
External Appeals Department