

November 14, 2005

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-2259-01
DWC #: _____
Injured Employee: _____
Requestor: _____
Respondent: Zurich American Insurance Company/F.O.L.
MAXIMUS Case #: TW05-0205

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308 which allows for a dispute resolution by an IRO.

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 who is board certified in neurosurgery on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. 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 female who sustained a work related injury on _____. The member reported that she injured her back while moving a patient from a bed to a chair. She noted that she felt a catch in her back and right shoulder and the next morning she experienced back and right shoulder pain. Evaluation and treatment for her condition has included therapy, shoulder injections, pain management, topical gel, medications, discogram, surgery, electrodiagnostic testing and psychotherapy. Diagnoses have included right shoulder strain and lower back strain, L4-5 and L5-S1 degenerative changes, thoracic outlet syndrome and mild spondylosis.

Requested Services

Arthrodesis pos/posterolat technique 1 level lumb, LSO Sagit coronal lumb-flex rigd PO, rental cryo-unit.

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

Documents Submitted by Requestor:

1. None submitted

Documents Submitted by Respondent:

1. Carrier's Position Statements – 9/23/05, 10/4/05
2. Carrier's Denial Letters – 6/17/05, 7/15/05
3. Physical Medicine & Rehabilitation Review of File – 6/2/05
4. MRI – 6/21/05
5. Designated Doctor Evaluation – 4/7/05

Decision

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

Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

Rationale/Basis for Decision

The MAXIMUS physician consultant indicated that there is no clear indication for operative intervention in this patient's case. The MAXIMUS physician consultant noted there is no evidence of spinal instability and no other documentation of medical necessity for the requested surgical procedure. The MAXIMUS physician consultant further indicated that there is no medical necessity for the requested cryo-unit. The MAXIMUS physician consultant noted that there is no established efficacy in the medical and scientific literature for this device. The MAXIMUS physician consultant also noted that use of a cryo-unit remains investigational in nature.

Therefore, the MAXIMUS physician consultant concluded that the requested Arthrodesis pos/posterolat technique 1 level lumb, LSO Sagit coronal lumb-flex rigd PO, rental cryo-unit is not medically necessary for treatment of the member's condition.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department

cc: Division of Workers Compensation

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 14th day of November 2005.

Signature of IRO Employee: _____
External Appeals Department