

October 18, 2005

VIA FACSIMILE:  
Jacob Rosenstein, MD  
Attention: Jennifer

VIA FACSIMILE:  
Parker Associates for Texas Builders Insurance Company  
Attention: William Weldon

### **AMMENDED NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-05-2362-01**  
**TWCC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: Jacob Rosenstein, MD**  
**Respondent: Parker Associates for Texas Builders Insurance Company**  
**MAXIMUS Case #: TW05-0193**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Division of Texas Worker's Compensation (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. DWC 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 DWC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery 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 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 MAXIMUS. 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 on \_\_\_\_\_. The patient reported that his 18- wheel tractor trailer flipped over on slick pavement when the rear tire blew out. He reported that he hit his head against the driver's window and twisted his neck and lower back resulting in pain. Diagnoses include mild facet arthropathy, pseudoarthritis, spinal stenosis, radiculopathy and herniated discs. Evaluation and treatment has included diagnostic studies,

chiropractic services, physical therapy, surgery and medications. A lumbar fusion L4-5 with a 3-day hospital stay was recommended for treatment of the member's condition.

### **Requested Services**

Preauthorization for lumbar fusion L4-5 with a 3-day length of stay.

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

#### *Documents Submitted by Requestor:*

1. Neurosurgery Office Notes – 5/23/05-8/25/05
2. Diagnostic Studies – 5/6/04, 11/10/04, 2/8/05

#### *Documents Submitted by Respondent:*

1. Diagnostic Studies (MRI, CT, X-rays, Discograms, Myelograms, Impairment Ratings) – 9/11/01-8/25/05
2. Operative Report – 11/7/02
3. Evaluations and Re-evaluations – \_\_\_-8/25/05
4. Chiropractic Records – 8/31/01-9/30/04
5. Physical Therapy Records – 9/21/01-9/6/05
6. Retrospective Peer Reviews – 10/15/02

### **Decision**

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

### **Rationale/Basis for Decision**

The MAXIMUS physician consultant indicated there is no clear indication for the requested lumbar fusion procedure and 3-day hospital stay. The MAXIMUS physician consultant noted the CT scan was essentially normal. The MAXIMUS physician consultant explained that the lumbar discogram was equivocal at best. The MAXIMUS physician consultant noted there was no clear concordancy or marked pain with injections during the lumbar discogram. The MAXIMUS physician consultant explained that there is clinical evidence provided to support the medical necessity of spinal fusion for this patient. (Cohen SP, et al. Lumbar discography: a comprehensive review of outcome studies, diagnostic accuracy, and principles. Reg Anesth Pain Med. 2005 Mar-Apr;30(2):163-83, Derby R, et al, Pressure-controlled lumbar discography in volunteers without low back symptoms. Pain Med. 2005 May-Jun;6(3):213-21; discussion 222-4, Landers PH, Lumbar Discography: current concepts and controversies. Semin Ultrasound CT MR. 2005 Apr;26(2):81-8.)

Therefore, the MAXIMUS physician consultant concluded that the requested lumbar fusion L4-5 with a 3-day length of stay is not medically necessary for treatment of this patient'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: Texas Workers Compensation Commission

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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 11th day of October 2005.

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