

October 5, 2005

[Claimant]

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

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-0009-01
TWCC #: ____
Injured Employee: ____
Requestor: ____
Respondent: Zurich American Insurance Company/F.O.L.
MAXIMUS Case #: TW05-0199

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 on _____. The patient reported that while lifting a heavy tote of frying pans and twisting, he felt something pop in his back. He also reported he had severe burning pain in his back and both buttocks. Diagnoses include pain disorder, adjustment disorder, lumbar radiculopathy, displaced disc, and chronic low back pain. Evaluation and treatments has included MRIs, myelograms, physical therapy, surgery, injections, chiropractic services and medication.

Requested Services

Preauthorization for a 3-day inpatient length of stay, anterior lumbar interbody fusion (ALIF) using intervertebral prosthesis & allograft bone at L5-S1 & concomitant posterolateral fusion using pedicle screws & rods through a tube retractor, open if necessary.

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 Statement – 9/12/05
2. Preauthorization Determinations – 6/29/05, 8/2/05
3. Diagnostic Studies (X-rays, MRIs, CT Scans, Myelograms, Electromyography and Electrodiagnostics) - 10/10/00-5/24/05
4. Pain Management Records – 10/15/04-4/13/05
5. Orthopaedic Records – 10/24/00-12/28/04
6. Garland Spine Center Evaluations – 5/23/05-6/13/05
7. Functional Testing – 10/5/04,
8. Consultations – 7/23/04, 7/24/04,
9. Behavioral Health Records – 12/6/04-5/3/05
10. Therapy Evaluation and Treatment Records – 2/8/01-4/13/05
11. Procedure Notes – 2/23/05, 3/16/05
12. Chiropractic Records – 7/2/04-2/16/05
13. Hospital Records – 8/5/98, 1/10/01, 10/29/03, 6/19/04, 11/1/04

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician consultant indicated that this member has had chronic pain since 2000 from a work related injury. The MAXIMUS physician consultant noted he has had multiple interventions with little long-term effect. The MAXIMUS physician consultant explained that he smokes and has a history of depression. The MAXIMUS physician consultant also indicated the member is a poor candidate for fusion or artificial disc surgery. The MAXIMUS physician consultant noted it is not likely that the proposed surgery will be effective based on the member's history, smoking, psychiatric factors and work injury pain for more than 4 years. The MAXIMUS physician consultant indicated the member is best served by continued non-operative measures such as physical therapy and a pain management program.

Therefore, the MAXIMUS physician consultant concluded that the requested 3-day inpatient length of stay, anterior lumbar interbody fusion (ALIF) using intervertebral prosthesis & allograft

bone at L5-S1 & concomitant proterolateral fusion using pedicle screws and rods through a tube retractor, open if necessary 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

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 5th day of October 2005.

Signature of IRO Employee: _____
External Appeals Department