

October 26, 2005

[Claimant]

VIA FACSIMILE:

City of Boerne c/o FOL

Attention: Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-0095-01
TWCC #: ____
Injured Employee: ____
Requestor: ____
Respondent: City of Boerne c/o FOL
MAXIMUS Case #: TW05-0211

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 (DWC) 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 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 he was lifting a dead tree and developed low back pain with radiation into both legs and some weakness and numbness in the legs. Evaluation and treatment have included bed rest, medications, chiropractic treatments and MRIs. Diagnoses have included degenerative disc disease, disc protrusion at L4-S1, mechanical low back pain, and bilateral lumbar radiculopathy secondary to disc herniations.

Requested Services

L4-S1 bilateral lumbar lami/foraminotomy & partial discectomy.

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

Documents Submitted by Requestor:

1. Office Notes – 5/11/05, 8/9/05
2. MRI – 4/14/05

Documents Submitted by Respondent:

1. Letters of Denial – 8/18/05, 9/7/05
2. Summary of Carrier's Position – 10/6/05

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 there is no clear rationale or supporting documentation for the proposed L4-S1 bilateral lumbar laminectomy/foraminotomy and partial discectomy surgical procedures. The MAXIMUS physician consultant explained that the efficacy of surgery of L4-5 is questionable at best. The MAXIMUS physician consultant noted there is no indication for the surgery at the L5-S1 level for this patient. (Vaccaro, et al. Principles of Practice of Spinal Surgery. 2004.)

Therefore, the MAXIMUS physician consultant concluded that the requested L4-S1 bilateral lumbar lami/foraminotomy & partial discectomy 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: Division of Texas Worker's 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 26th day of October 2005.

Signature of IRO Employee: _____
External Appeals Department