

January 19, 2006

VIA FACSIMILE
City of Houston/Cambridge
Attention: Tim Lott

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-0492-01
DWC #:
Injured Employee: ____
Requestor: ____
Respondent: City of Houston/Cambridge
MAXIMUS Case #: TW05-0252

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 orthopedic surgery 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 an adult male who sustained a work related injury on _____. The patient reported that while carrying boxes of typed papers, he slipped landing heavily on his buttocks. He also reported that he developed instant onset of low back pain. Diagnoses included large central disc herniation, disc disease, strain of lumbar region, lumbar radiculitis and low back pain. Evaluation and treatment have included chiropractic treatment, an MRI and physical therapy.

Requested Services

Preauthorization Request for Charite lumbar artificial disc replacement L5-S1, and ten day cryo unit rental

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

Documents Submitted by Requestor:

1. None submitted

Documents Submitted by Respondent:

1. Cambridge Peer Review Report – 11/2/05, 11/14/05
2. Spine Associates of Houston, LLC Records – 10/24/05-10/25/05
3. Steeplechase Diagnostic & Open MRI – 10/14/05
4. Chiropractic Records – 10/12/05-10/24/05

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 this patient has 3 levels of lumbar disc degeneration. The MAXIMUS physician consultant noted the patient had a previous laminectomy at L5-S1. The MAXIMUS physician consultant explained that these are contraindications to artificial disc replacement. The MAXIMUS physician consultant also indicated that artificial disc replacement is experimental at this time as there are no long-term follow-up studies to support its efficacy at this time. The MAXIMUS physician consultant noted that more data is needed to establish the mid and long-term efficacy of this procedure. The MAXIMUS physician consultant also noted that there is no data to support the efficacy of a cryo unit for treatment of this patient's condition.

Therefore, the MAXIMUS physician consultant concluded that the requested preauthorization request for Charite lumbar artificial disc replacement L5-S1, and ten day cryo unit rental 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 19th day of January 2006.

Signature of IRO Employee: _____
External Appeals Department