

March 8, 2006

VIA FACSIMILE
American Home Assurance Company
Attention: Raina Robinson

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-0767-01
DWC #:
Injured Employee:
Requestor:
Respondent: American Home Assurance Company
MAXIMUS Case #: TW06-0025

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 lifting a heavy box of chlorophine he developed low back pain. Diagnoses included lumbar pain/strain, muscle spasms, lumbar intervertebral disc disorder with myelopathy, lumbar radiculopathy, insomnia secondary to chronic pain. Evaluation and treatment have included medications, MRI and physical therapy.

Requested Services

Preauthorization for laminectomy/discectomy L6/S1 left side, posterior spinal fusion L6/S1 ICBG, pedicle screws/rods, anterior spinal fusion L6/S1, custom LSO brace, and 10 days 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. New England Journal of Medicine Articles – 2/12/04, 5/5/05
2. Employer's First Report of Injury or Illness – not dated
3. Denial Notifications – 1/4/06, 1/16/06
4. Concentra Medical Centers Records – 8/1/02-11/7/03
5. Diagnostic Reports – 11/4/03, 8/30/05
6. Orthopedic Records 11/14/03-1/24/06
7. Pain & Spinal Rehabilitation Institute Records – 10/28/03
8. Texas Workers Compensation Commission Decision and Order – 9/2/04
9. Gulf Freeway Health Clinic Records – 8/12/04
10. Texas Pain Institute Records – 8/18/04-1/24/06
11. Required Medical Examination – 8/19/04
12. Functional Abilities Evaluation – 8/19/04
13. Spine Associates of Houston Records – 10/5/04-12/27/05
14. Spine Resource Consultants Records – 8/17/05
15. Allendale Bone & Joint Clinic – 12/21/05
16. Operative Report – 1/20/06
17. Physical Therapy Notes – 9/6/01-10/8/04
18. HealthSouth Records – 11/24/03
19. Memorial Hermann Southeast Records – 8/3/02

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's back and leg symptoms are not likely to improve with laminectomy and fusion surgery. The MAXIMUS physician consultant explained the MRI dated 8/30/05 reports diffuse degenerative changes involving multiple levels from S1 through L3. The MAXIMUS physician consultant noted that surgery at a single level (L6-S1) is not likely to be effective. The MAXIMUS physician consultant also explained that the literature does not support surgery in this case. The MAXIMUS physician consultant indicated that the literature does not support fusion surgery for treatment of this patient's condition. The MAXIMUS physician consultant noted the patient is not a good candidate for surgery given his multi-level degenerative pathology. The MAXIMUS physician consultant also noted that

cryotherapy is not medically indicated for treatment of this patient's condition. The MAXIMUS physician consultant explained that the literature does not support the use of cryotherapy for the spine. (Gibson, et al. Cochrane Data System Rev. 2005 Oct 19; (4); Van Talden. Eur Spine S. 2006)

Therefore, the MAXIMUS physician consultant concluded that the requested laminectomy/discectomy L6/S1 left side, posterior spinal fusion L6/S1 ICBG, pedicle screws/rods, anterior spinal fusion L6/S1, custom LSO brace, and 10 days cryo unit rental are 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 8th day of March 2006.

Signature of IRO Employee: _____
External Appeals Department