

April 14, 2006

VIA FACSIMILE

Argonaut Ins Co/Downs & Stanford

Attention: W. Jon Grove

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-1013-01

DWC #:

Injured Employee:

Requestor:

Respondent: Argonaut Insurance Company/Downs & Stanford

MAXIMUS Case #: TW06-0052

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 female who sustained a work related injury on _____. The patient reported that she squatted down and felt severe pain in her lower back. Evaluation and treatment have included injection therapy, physical therapy and medications. Diagnoses have included lumbar radiculopathy with instability and disc protrusion.

Requested Services

Preauthorization for lumbar decompression, posterior fusion L4-5

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

Documents Submitted by Requestor:

1. Determination Notices – 12/29/05, 1/18/06
2. Letter from Gary T. Evans, MD – 3/7/06
3. Correspondence from Injured Worker – 1/11/06, 1/23/06, 3/8/06
4. Consultation (William D. Bradley, MD) – 12/13/05

Documents Submitted by Respondent:

1. Texas Back institute Records and Correspondence – 7/18/05-10/31/05
2. Determination Notices – 12/29/05, 1/18/06
3. The Rehab Center Records and Correspondence – 10/25/05
5. North Texas Rehabilitation Center Records and Correspondence – 10/12/05-11/17/05
6. Records from Gary Evans – 7/26/05-8/15/05
7. Diagnostic Studies (i.e., MRI, x-rays, etc) – 7/18/05, 8/19/05

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 CHDR physician reviewer indicated the patient has multiple diagnoses that include low back strain and osteoporosis. The MAXIMUS CHDR physician reviewer noted that spinal fusion is not likely to be successful for treatment of this patient's condition. The MAXIMUS CHDR physician reviewer explained that the literature does not support fusion surgery in this case. (van Tulder M, et al. Outcome of non-invasive treatment modalities on back pain: an evidence-based review. Eur Spine J. 2006 Jan;15 Suppl 1:S64-81. Epub 2005 Dec 1.)

Therefore, the MAXIMUS physician consultant concluded that the requested lumbar decompression, posterior fusion L4-5 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 14th day of April 2006.

Signature of IRO Employee: _____
External Appeals Department