

April 26, 2006

VIA FACSIMILE

SORM

Attention: Jennifer Dawson

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-1144-01
DWC #:
Injured Employee:
Requestor:
Respondent: SORM
MAXIMUS Case #: TW06-0058

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 anesthesiology 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 a 65-year old male who had a work related injury on _____. The member reported that he slipped on a wet floor sustaining injury to his low back and right elbow. Diagnoses included post laminectomy syndrome, displacement of lumbar intervertebral disc without myelopathy, thoracic or lumbosacral neuritis or radiculitis. Treatment has included surgeries, spinal cord stimulator, medications, and injections.

Requested Services

Preauthorization for outpatient right psoas block injection of Botox and five Botox trigger point injections as related to low back pain and bilateral lower extremities (BLE).

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

Documents Submitted by Requestor:

1. None submitted

Documents Submitted by Respondent:

1. External Medical Review – 7/26/05
2. Behavioral and Psychological Records – 1/10/02-5/14/02
3. Diagnostic Studies (i.e., x-rays, CT scans, MRIs, etc) – 2/4/02, 5/5/05, 5/23/05, 3/10/05.
4. Texas Back Institute Records – 10/24/01-2/21/05
5. Family Care Center Records – 2/4/04-3/12/02
6. Parker Road Surgery Center Records – 2/13/02
7. Pain Medicine Records – 1/12/05-3/14/06
8. Midland Memorial Hospital – 2/8/05
9. Retrospective Medical Record Review – 7/1/03
10. Independent Medical Evaluation – 7/11/05
11. Determination Notifications – 3/13/06, 3/14/06, 3/20/06, 3/21/06

Decision

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

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 case concerns a 65-year old male who sustained a work related injury on ___ when he slipped on a wet floor and fell injuring his low back and right elbow. The MAXIMUS physician consultant noted that the documentation clearly demonstrates he has a work related chronic pain condition and has undergone multiple conservative and interventional therapies but still continues with ongoing low back pain felt to be myofascial in origin. The MAXIMUS physician consultant also noted that despite multiple medications including nonsteroidal anti-inflammatory medications, muscle relaxants, opiate and non-opiate medications in conjunction with physical therapy and interventions (multiple surgeries, implantation of a spinal cord stimulator, trigger point injections), the patient continues with daily pain. The MAXIMUS physician consultant explained that evaluations have indicated he should continue under the care of a pain management specialist. The MAXIMUS physician

consultant indicated the patient responded to previous psoas compartment plexus block/trigger point injections. The MAXIMUS physician consultant also indicated that Botox is considered appropriate therapy for myofascial pain as it may prolong pain relief in this setting. The MAXIMUS physician consultant explained that the patient has exhausted all interventions for long-term pain control and a trial of Botox therapy seems appropriate and medically necessary at this time.

Therefore, the MAXIMUS physician consultant concluded that the requested outpatient right psoas block injection of Botox and five Botox trigger point injections as related to low back pain and bilateral lower extremities (BLE) is 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 26th day of April 2006.

Signature of IRO Employee: _____
External Appeals Department