

September 1, 2006

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VIA FACSIMILE  
North American Specialty Insurance  
Attention: Susan Whitley

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-06-1842-01**  
**DWC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: \_\_\_\_\_**  
**Respondent: North American Specialty Insurance**  
**MAXIMUS Case #: TW06-0126**

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 had a work related injury on \_\_\_\_\_. Records report that she slipped on a wet floor in a restroom and landed on her back. Diagnoses have included lumbosacral strain, coccydynia, and lumbar disc degeneration. Evaluation and treatment for this injury has included an MRI, injections, and physical therapy.

## Requested Services

Preauthorization for coccygectomy.

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

### *Documents Submitted by Requestor:*

1. South Texas Spinal Clinic, PA records and correspondence – 4/12/06-7/7/06
2. Determination Notices – 5/16/06, 6/26/06, 7/18/06
3. Laredo Pain Center records and correspondence – 3/1/05
4. Laredo Open MRI – 5/17/06

### *Documents Submitted by Respondent:*

1. Summary of Carrier's Position – 8/16/06
2. Determination Notices – 6/26/06, 7/18/06
3. Laredo Open MRI – 5/17/06
4. South Texas Spinal Clinic, PA records and correspondence – 4/12/06, 5/31/06
5. Maximum Medical Improvement and Impairment Rating Evaluation – 3/7/06
6. MRI interpretation by Richard A. Suss, MD, PA – 11/5/05

## 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 a coccygectomy procedure is not likely to be successful for this patient with chronic back pain and lumbar disc degeneration. The MAXIMUS physician consultant noted that this patient has had pain since 2001. The MAXIMUS physician consultant explained that additional intervention/surgery at this time is unlikely to be successful as the patient has lumbar disc degeneration and multiple sources of chronic back pain. (Hodges SD, et al. A treatment and outcomes analysis of patients with coccydynia. Spine J. 2004 Mar-Apr; 4(2): 138-40. van Tulder MW, et al. Outcome of Invasive Treatment for Low Back Pain, Eur Spine J. 2006.)

Therefore, the MAXIMUS physician consultant concluded that the requested preauthorization for coccygectomy is not medically necessary for treatment of the 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 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 1st day of September 2006.

Signature of IRO Employee: \_\_\_\_\_  
External Appeals Department