

May 13, 2005

VIA FACSIMILE  
Jacob Rosenstein  
Attn: Cheryl

VIA FACSIMILE  
Ward North America  
Attn: Helen Garcia

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-1419-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Jacob Rosenstein**  
**Respondent: Ward North America**  
**MAXIMUS Case #: TW05-0083**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

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 on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in anesthesiology and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. 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 female who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work she injured her low back when she was loading coolers full of water and ice onto a cart. On 12/8/97 the patient underwent a lumbar MRI that showed a moderate to large right sided, paracentral disc herniation at L5-S1 considered to be an extrusion. A repeat lumbar MRI performed on 12/7/04 revealed findings that included lumbar hyporlordosis associated with desiccation of the disks at L3 through S1 and thinning of the disks L4 through S1, a 2mm broad

based disk protrusion at L5-S1 with eccentric extension to the right of midline contacting the descending S1 nerve root on the right, and a 2mm focal disc protrusion at L4-5. The diagnoses for this patient include low back pain, central disc protrusion at L4-5 and L5-S1, and disc desiccation at L3-4, L4-5, and L5-S1. Treatment for this patient's condition has included physical therapy, chiropractic care, and electrical stimulation.

### Requested Services

Lumbar epidural steroid injection.

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

#### *Documents Submitted by Requestor:*

1. History, Physical and Neurological Examination 2/23/05
2. Follow Up 4/6/05 and 4/14/05

#### *Documents Submitted by Respondent:*

1. Medical Record Review 4/1/05, 4/21/05
2. MRI report 12/7/04, 12/8/97
3. History, Physical and Neurological Examination 2/23/05
4. SOAP Notes 4/14/04 – 10/27/04

### Decision

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

### Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a 32 year-old female who sustained a work related injury to her back on \_\_\_\_\_. The MAXIMUS physician reviewer indicated that an MRI of the lumbar spine performed on 12/8/97 revealed a paracentral disc herniation at the L5-S1 level and that a repeat MRI performed in 12/2004 demonstrated facet arthrosis throughout the lumbar range, a 2-3mm disc protrusion at the L4-5, a 2mm broad based disc protrusion at the L5-S1, and lumbar hypolordosis associated with disc desiccation at L3-S1 with associated degenerative disc disease. The MAXIMUS physician reviewer noted that treatment for this patient's condition has included medical therapy, physical therapy, chiropractic care, and electrical stimulation. The MAXIMUS physician reviewer indicated that the patient has continued complaints of lower back pain and that the patient has been recommended for epidural steroid injection therapy for pain control.

The MAXIMUS physician reviewer noted that the most recent MRI from 12/2004 demonstrated degenerative changes in the lumbar spine at the levels L3-S1 that were present on the MRI performed in 12/1997 that appear to have worsened. The MAXIMUS physician reviewer also noted that there is a new injury to the lumbar spine at the L4-5 levels that was not present on the 12/1997 MRI. The MAXIMUS physician reviewer indicated that the patient's continued complaints of back pain are the result of arthrosis and degenerative disc disease. The

MAXIMUS physician reviewer also indicated that the patient reached maximum medical improvement and received a 6% impairment rating in 1997. The MAXIMUS physician reviewer explained there is no evidence that the patient is currently on or has tried and failed a course of medical therapy. Therefore, the MAXIMUS physician consultant concluded that the requested lumbar epidural steroid injections are not medically necessary to treat this patient's condition at this time.

**This decision is deemed to be a TWCC Decision and Order.**

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
P.O. Box 17787  
Austin, TX 78744

Fax: 512-804-4011

**A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

**MAXIMUS**

Elizabeth McDonald  
State Appeals Department

cc: Texas Workers Compensation Commission

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 13th day of May 2005.

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