

February 11, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0412-01
IRO Certificate No.: I RO 5055

Dear:

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IRO's, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

This independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a Board Certified Orthopedic Surgeon.

THE REVIEWER OF THIS CASE **AGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your

receipt of this decision (28 Tex. Admin. Code 102.4(h)). A request for hearing should be sent to: Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

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.

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 23rd day of April, 2002.

Sincerely,

Secretary & General Counsel

MEDICAL CASE REVIEW

This is ___ for ___. I have reviewed the medical information forwarded to me concerning Case MDR #M2-02-0412-01, in the area of Orthopedic Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

All the material furnished me regarding the patient, date of injury ___, including:

1. Office notes and letters of his treating physician, M.D., beginning with the office visit of 10/03/96, through his correspondence of 1/07/02.
2. The notes of three previous examiners who had seen the patient for evaluation and/or treatment:
3. MRI studies, dated 10/10/96 and 11/14/01.
4. EMG, 10/30/01.
5. Comments of examiner, ___ 12/25/01.

B. SUMMARY OF EVENTS:

The patient reported the onset of low back pain while working on ___. He sought medical attention the following day from ___. A favorable response to treatment is described, with final disability ratings of 9% and 6% after reaching maximum improvement.

Next, he consulted ___ who treated him through November 1996; the last described procedure, an epidural steroid injection on 11/08/96.

He next saw ___ on 10/18/01; had x-rays, an EMG, and a second MRI on 11/14/01.

C. OPINION:

I AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

The effects of the alleged injury on ___ had been resolved. In my opinion, subsequent low back complaint five years later is unrelated to a ___ injury. There is no logical reason to assume a second epidural steroid injection would have been any more beneficial than the first.

D. ADDITIONAL COMMENTS:

None.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 9 February 2002