

April 12, 2002

LETTER AND REPORT CORRECTING
CORRESPONDENCE OF 04/10/02

Re: Medical Dispute Resolution
MDR #: M2-02-0429-01
IRO Certificate No.: IRO 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. This case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

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,

MEDICAL CASE REVIEW

This is for ____. I have reviewed the medical information forwarded to me concerning MDR #M2-02-0429-01, in the area of Orthopedic Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for Medical Dispute Resolution concerning the necessity of decompressive left lumbar laminectomy, diskectomy, and the response.
2. Clinical notes.
3. Report of imaging study.

B. SUMMARY OF EVENTS:

This case involves a 30-year-old male with alleged back injury and Injury to his left forearm, incurred in a fall on ____. He was examined on 10 July 2001, and no abnormal physical findings were detected to indicate a serious injury. X-rays, physical therapy, nonsteroidal anti-inflammatory agents, and muscle relaxants were requested.

By 13 August 2001, the patient reports some improvement. Examination continues to show no motor nor sensory deficit, and his deep tendon reflexes in the lower extremities remained symmetrically normal.

On 5 September 2001, an MRI study suggested bulging disks at the lower three lumbar levels, with possibly a small disk herniation with left L-5 nerve root impingement. Subsequent clinical exam continued to reveal normal sensory and motor findings.

C. OPINION:

1. I AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.
2. The clinical examination does not support an indication for surgery, in my opinion. On repeated exams, the motor and sensory findings are recorded as normal, deep tendon reflexes symmetrically normal, and he had no indication of a progressive neurological deficit. The MRI findings, in my opinion, are minimal and do not sufficiently demonstrate a surgical lesion. I find no necessity for surgical intervention at the present time.

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: 2 April 2002