

March 18, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0457-01
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 IROs, 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.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Anesthesiology and Pain Management.

THE PHYSICIAN 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 18th day of February, 2002.

Sincerely,

Secretary & General Counsel

Enclosure

cc:

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning TWCC Case _____, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for medical dispute resolution case review.
2. _____ documentation and information.
3. The records of 1998, 1999, 2000, 2001, and 2002.

B. SUMMARY OF EVENTS:

The patient is a 50-year-old lady who was apparently injured in a work-related accident on _____. She apparently slipped and fell on a wet floor, fell backwards and hit her back and her shoulder on the wall. She was initially treated conservatively and subsequently was referred to _____ for further care and pain management. She has undergone several procedures including epidural steroid injections, S-I joint injections including rhizotomy of the S-I joint, facet injections, and physical therapy including aquatherapy. She continues to have pain.

The purpose of this review is to determine whether or not an open Coblation® nucleoplasty at levels L4-5 and L5-S1 is medically necessary.

C. OPINION:

AFTER REVIEWING ALL OF THE RECORDS PRESENTED TO ME, I AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT IN THIS CASE.

This patient has undergone several procedures in her care including an IDET procedure and has failed that. She has had a diskogram following that, and the diskogram would not substantiate the need for further nucleoplasty, and, therefore, the requested procedure is not medically necessary.

Although I agree with the attempts at conservative care, it seems that this patient needs surgical intervention, and my recommendation would be such.

D. 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: 14 March 2002