

April 1, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0480-01
TWCC File #:
Injured Employee:
IRO Certificate No.:

___ 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 Neurology 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 8th day of February, 2002.

Sincerely,

Secretary & General Counsel

MEDICAL CASE REVIEW

This is ___ M.D. for ___. I have reviewed the medical information forwarded to me concerning Case File #M2-02-0480-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution request.
2. ___ documentation and information.
3. Records from 1999.
4. Records from 2000.
5. Records from 2001.
6. Records from 2002.

B. SUMMARY OF EVENTS:

The patient's extensive medical history was reviewed with the documentation provided. I will not summarize the entirety of the record other than to note that the initial date of injury is recorded as being ___, and the procedure request in question regards a series of three lumbar epidural steroid injections reinforced with a spinal epidural catheter@ by Dr. ___.

C. OPINION:

I am of the opinion that a series of epidural steroid injections at this time would be of low utility in treatment of this chronic and persistent pain syndrome.

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

Even the note provided by ___, under Assessment,@ lists several diagnoses, none of which includes radiculopathy or nerve root related pain. A post lumbar laminectomy syndrome,@ which would be presumably due to scar tissue / A epidural fibrosis,@ would not be expected to respond in any lasting manner to a series of steroid injections.

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.

_____, M.D.

Board-Certified by the American Board of Psychiatry and Neurology -
in Neurology and Pain Management

Date: 29 March 2002