



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

October 29, 2002

Requestor

Kenneth G. Berliner, MD
Attn: Brenda Gonzalez
15769 N. Freeway
Houston, TX 77090

Respondent

American Home Assurance Company
c/o The Hartford
P.O. Box 130927
Dallas, TX 75313

RE: Injured Worker:
MDR Tracking #: M2-03-0061-01
IRO Certificate #: IRO 4326

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a _____ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The _____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to _____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 49 year old female sustained a work-related injury on 9/22/00 when she was moving some boxes and experienced low back pain and right hip pain. The patient has objective evidence of pathology on MRI at L4-5. A lumbar discogram indicates that the patient also has concordant pain with abdominal disc morphology at L3-4 and L4-5 with normal control level at L5-S1. The patient has complaints of ongoing pain and the treating physician has recommended that the patient undergo intradiscal electrothermal therapy (IDET).

Requested Service(s)

IDET

Decision

It is determined that IDET is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record fails to substantiate the medical necessity for the IDET procedure. There is no documentation contained in this patient's medical record that would indicate that the IDET procedure would produce any better or more long-term relief from her symptoms than conservative treatment. Therefore, it is determined that the IDET is not medically necessary to treat this patient's condition.

This decision by the IRO 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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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 (Commission Rule 133.308 (t)(2)).

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Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

cc: Injured Worker
Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), 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 29th day of October 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: