



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M2-06-1933-01
NAME OF REQUESTOR: _____
NAME OF PROVIDER: Michael Yen, M.D. Ophthalmology
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 10/16/06

Dear Mr. ____:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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.

This case was reviewed by a physician reviewer who is Board Certified in the area of Ophthalmology and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates 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 the provider, the injured employee, the injured

M2-06-1933-01

Page Two

employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An Employer's First Report of Injury or Illness dated 05/07/04

An evaluation with Michael T. Yen, M.D. dated 03/15/06

A CT scan of the maxillofacial area interpreted by Susan Weathers, M.D. dated 03/15/06

An evaluation with Stephen C. Pflugfelder, M.D. dated 04/24/06

Notes from an unknown provider (the signature was illegible) dated 05/10/06 and 06/14/06

A letter from Dr. Yen dated 06/27/06

Letters of denial from Corvel dated 08/04/06 and 08/11/06

Clinical History Summarized:

On 03/15/06, Dr. Yen recommended a CT scan of the orbits. A CT scan of the maxillofacial area interpreted by Dr. Weathers on 03/15/06 revealed post right orbital floor and medial wall blowout fractures with good positioning of the orbital floor plate and inferior orbital rim plate and slight enophthalmos. On 04/24/06, Dr. Pflugfelder removed some of the sutures on the transplant and recommended evaluation for glasses or contact lenses. On 05/10/06, Dr. Pflugfelder recommended Lotemax and Restasis. On 06/14/06, the unknown physician recommended an enophthalmos wedge implant, an orbital rim implant, and removal of the titanium hardware. Dr. Yen wrote a letter "To Whom It May Concern" on 06/27/06 recommending preauthorization for additional surgery. On 08/04/06 and 08/11/06, Corvel provided letters of denial for the additional surgery.

Disputed Services:

Removal of orbital titanium hardware and enophthalmos wedge implant

Decision:

I disagree with the requestor. The removal of the orbital titanium hardware and enophthalmos wedge implant would not be reasonable or necessary.

Rationale/Basis for Decision:

The patient's malar flattening and enophthalmos are directly related to his injury. His injury was two years prior. However, he has been having no functional deficits from those injuries. He has no double vision or pain with movement. He only has cosmetic deformity that has already been repaired once. The orbital hardware seen on the CT scan in my notes is entirely normal, with no signs of inflammation or damage. Therefore, the patient has had two years of those orbital deformities with no question as to repairing them. Now that the option has been brought to his attention, he seemed intent on repairing those for a purely cosmetic reason. There is definitely no medical necessity for the patient to have this surgery to place him in an optic wedge implanted in the right eye and an orbital rim implant, considering the titanium hardware in his orbit now has not been causing him any problems. Again, I feel this surgery would be purely cosmetic in nature and not medically necessary.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

M2-06-1933-01

Page Four

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

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's decision was sent to the respondent, the requestor, DWC, and the patient via facsimile or U.S. Postal Service this day of 10/16/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel