

NOTICE OF INDEPENDENT REVIEW DECISION

December 23, 2003

MDR Tracking #: M2-04-0474-01
IRO Certificate #: IRO4326

The ___ 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 pain management 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 patient was injured on ___ when his truck popped out of gear and he attempted to hit the break with his hand, hurting his back and hip. He has been seeing a pain management physician for trigger point injections and ilioinguinal nerve blocks.

Requested Service(s)

Left ilioinguinal radiofrequency thermocoagulation

Decision

It is determined that the proposed left ilioinguinal radiofrequency thermocoagulation is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has persistent left inguinal pain with radiation to the testicular area and thigh. He was seen by a surgeon who felt surgery was not the best option. He has a history of multiple groin surgeries. The patient's medical history is consistent with ilioinguinal nerve injury. The physical examination performed 07/16/03 showed allodynia in the left inguinal region, which is consistent with nerve injury. The patient has had extensive non-invasive treatment including multiple medications including Neurotin and opiate medications, physical medicine evaluation and treatment, and behavioral treatment.

He underwent three injections with local anesthetic, which consistently allowed short-term relief, making him a good candidate for radiofrequency neurolysis. Therefore, it is determined that the proposed left ilioinguinal radiofrequency thermocoagulation is medically necessary.

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** (ten) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

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 23 rd day of Decmeber 2003.
