

January 6, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-0008-01
IRO Certificate No.: IRO 5055

Dear:

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 who is Trained and Board Certified in Chiropractic Medicine.

I am ___ 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 simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

Clinical History:

This claimant is a 40-year-old male who injured his left shoulder on ____.

Disputed Services:

MRI of left shoulder.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedure in question is medically necessary in this case.

Rationale for Decision:

The carrier's denial of the MRI was based on the lack of continued need for conservative care after surgery on 02/18/02. The patient had undergone extensive physical therapy, injections, and work

hardening, but was still unable to return heavy status for work due to pain rated as a 5 on a scale of 1 to 10. The evaluation upon discharge from work hardening determined there was still destruction in the left shoulder and that additional imaging may be necessary to determine where the impingement is. Also, on 08/09/02, CMT and range of motion tests revealed decreased range of motion.

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.

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 ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a 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 January 6, 2003.

Sincerely,