

October 6, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-03-1715-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in orthopedic surgery. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 55 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she was reaching up with her right arm when she experienced a popping sensation and then pain in her right shoulder. The patient is status post shoulder injury on \_\_\_ and had also undergone shoulder surgery for that injury. The patient underwent X-Rays of the right shoulder. The patient has been treated with physical therapy and medications. The diagnoses for this patient include shoulder pain with AC hypertrophy, arthritis and re-tear rotator cuff, possible biceps tendonopathy.

### Requested Services

Repeat MRI of the right shoulder.

### Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

The \_\_\_ physician reviewer explained that the history and clinical exam clearly direct the diagnosis and treatment of this patient's condition. The \_\_\_ physician reviewer indicated that the requested MRI would not provide information that will impact on clinical decision making regarding this patient's treatment. The \_\_\_ physician reviewer explained that if physical therapy is not successful, surgery could be required. However, the \_\_\_ physician reviewer also explained that the requested MRI would not assist in making this determination. The \_\_\_ physician reviewer also explained that if surgery is required, arthroscopic evaluation would be

recommended and both diagnostics and treatment would be possible. Therefore, the \_\_\_\_\_ physician consultant concluded that the requested repeat MRI of the right shoulder is not medically necessary to treat this patient's condition at this time.

This decision 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)** 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 a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
P.O. Box 17787  
Austin, TX 78744  
Fax: 512-804-4011

### **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)).

Sincerely,

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 6<sup>th</sup> day of October 2003.