

April 5, 2004

Re: MDR #: M2-04-0924-01
IRO Certificate No.: 5055

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.

I am the Secretary and General Counsel of ___ 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 care for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is certified in Chiropractic Medicine and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

Correspondence
History & physical exam and office notes
Physical therapy notes
Functional Capacity Evaluation
Operative and Radiology reports

Clinical History:

The records indicate the patient was initially injured on the job on _____. An evaluation was performed and an aggressive treatment program was begun. Over the course of treatment, appropriate diagnostic was ordered. In addition to conservative treatment, the patient had 2 rotator cuff repair surgeries of her right shoulder and surgery of her right knee. She also had postoperative rehabilitation. The records indicate the patient has had ongoing problems since her date of injury. A functional ability evaluation performed on January 20, 2004 reveals continuation of subjective symptomatology, as well as positive objective findings.

Disputed Services:

Post-operative MRI to right shoulder and right knee

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that an MRI of the right shoulder and right knee is medically necessary in this case.

Rationale:

There is sufficient documentation in this evaluation to warrant additional diagnostic testing in order to assist with determination of additional treatment. It is, in fact, reasonable, usual, customary, and medically necessary for this patient to undergo an additional MRI of the right shoulder and MRI of the right knee. The results of these examinations will assist in determination if additional surgical intervention is warranted. If surgical intervention is not needed, then this patient needs to progress into a chronic pain management program in an attempt to appropriately deal with the fact that the patient perceives that pain affects all areas of her daily activities. There are no national treatment guidelines, which allow for continuation of passive or active therapy years after surgical intervention. However, if the MRI reveals surgical intervention is needed and surgery is performed, than a 4-6 week postoperative rehabilitation program will be appropriate with release to a home exercise program in her case.

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.

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, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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 April 5, 2004.

Sincerely,