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NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 3, 2004

Requester/ Respondent Address:

TWCC
Attention: Gail Anderson
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

Advanced Neurological
Attn:
Fax: 281-842-1794
Phone: 281-842-1338

Fort Bend ISD c/o Harris & Harris
Attn:
Fax: 512-346-2539
Phone: 512-346-5533

RE: Injured Worker:

MDR Tracking #: M2-05-0326-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 chiropractic reviewer, who has an ADL certification. 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.

Submitted by Requester:

- Letter dated 11/15/04 from Advance Neurological Associates Dr. K, D.C.
- MDR for Prospective Pre-Authorization dated 10/20/04 from Advance Neurological Associates Dr. S, D.C.
- Request for Reconsideration for Pre-Certification dated 10/14/04 Dr. P, M.D.
- Pre-Authorization Rational dated 10/14/04 from CorVel
- Letter of Medical Necessity dated 10/11/04 from Advance Neurological Associates
- Work Conditioning & Management Evaluation dates 5/26/04, 7/28/04 and 9/22/04 from Dr. C, D.C.
- MRI of the left shoulder dated 6/10/04 from Universal MRI Town and Country
- Guideline in Electrodiagnostic Medicine
- Rational for Pre-Authorization dated 10/19/04 from CorVel
- Pre-Authorization Request dated 10/12/04

Submitted by Respondent:

- Pre-Authorization from CorVel dated 10/15/04
- Pre-Authorization from CorVel dated 10/20/04
- Peer Review dated 8/9/04 from Dr. B, D.C.
- Orthopedic Evaluation dated 6/29/04 from Dr. J, M.D.
- Work-Conditioning & Management evaluation dated 7/2/04 from Dr. C, D.C.
- Orthopedic Evaluation dated 7/20/04 from Dr. Y, M.D.

Clinical History

I have had the opportunity to review the medical records in the above-mentioned case for the purpose of an Independent Review. The claimant is a 57 year-old female who injured her left shoulder when she slipped and fell hitting her left shoulder on the floor while cleaning bleachers for Fort Bend ISD on _____. The claimant was initially treated by Dr. C, D.C. on 11/30/03 for left shoulder pain radiating into the head and mid back.

The claimant had an MRI of the left shoulder performed on 6/10/04 which revealed a 10mm tear of the supraspinatus tendon. There is a gap of 12mm. The tendon is thickened. There is no fatty degeneration of the supraspinatus muscle. There is effusion of the glenohumeral joint and with tenosynovitis of the biceps tendon and effusion of the sub acromial bursa. There is a Type IV acromion process with hypertrophy of the AC joint and an impingement syndrome. The claimant was evaluated for orthopedic consult with Dr. J, M.D. who recommended the claimant have surgical repair of the left rotator cuff. The claimant symptoms in her left shoulder have improved slightly with some strength loss and sensory deficit as revealed in the follow-up evaluation performed by Dr. C, D.C. on 9/22/04

Requested Service(s)

Please address prospective medical necessity of the proposed EMG/NCV consult evaluation of the left upper extremity with F wave, regarding the above mentioned claimant.

Decision

I disagree with the insurance carrier and find that the requested EMG/NCV evaluation is medically reasonable and necessary with regards to the above referenced claimant.

Rationale/Basis for Decision

The claimant has a rotator cuff injury as evident on the MRI findings dated 6/10/04 with progressive changes in the claimant’s condition of motor weakness and sensory deficit as described by Dr. C, D.C. follow-up office visit dated 9/22/04. This study would rule-out nerve injury associated with the compensable event and if neurological consult is warranted.

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 a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
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 the other party involved in this dispute.

<p>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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this ___3rd___ day of ___December___ 2004.</p> <p>Signature of IRO Employee:</p> <p>Printed Name of IRO Employee:</p>
