

January 3, 2006

VIA FACSIMILE
Jacob Rosenstein, MD
Attention: Jennifer Negri

VIA FACSIMILE
Insurance Company of the State of PA/F.O.L.
Attention: Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-0478-01
DWC #: _____
Injured Employee: _____
Requestor: Jacob Rosenstein, MD
Respondent: Insurance Company of the State of PA/F.O.L.
MAXIMUS Case #: TW05-0249

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308 which allows for a dispute resolution by an IRO.

MAXIMUS 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 who is board certified in orthopedic surgery on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns an adult male who sustained a work related injury on _____. Records indicate he was seen by his treating provider on 10/11/05 and complained of right shoulder pain. Records from an office visit dated 10/11/05 noted examination revealed crepitus of the right shoulder, decreased flexion and internal rotation. The records also noted the patient complained of numbness and tingling in the right thumb and index finger, and that his shoulder pain was worsening. Diagnoses included right carpal tunnel syndrome and right shoulder pain, probably tendonitis.

Requested Services

Preauthorization Request for MRI Right Shoulder (Upper Extremity)

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Follow-up Neurosurgery Office Visit – 10/11/05
2. Appeal Request – 11/9/05

Documents Submitted by Respondent:

1. Summary of Carrier's Position – 12/19/05
2. Review Determinations – 11/8/05, 11/15/05

Decision

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

Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

Rationale/Basis for Decision

The MAXIMUS physician consultant indicated there is insufficient evidence to justify an MRI of the shoulder procedure in this case. The MAXIMUS physician consultant noted the member was evaluated by a neurosurgeon. The MAXIMUS physician consultant explained there is no evidence to indicate he was evaluated by orthopedic specialist for his shoulder condition. The MAXIMUS physician consultant also indicated there is no documentation indicating the member had a trial of physical therapy prior to this request.

Therefore, the MAXIMUS physician consultant concluded that the requested MRI right shoulder (upper extremity) is not medically necessary for treatment of the member's condition.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department

cc: Division of Workers Compensation

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 3rd day of January 2006.

Signature of IRO Employee: _____
External Appeals Department