



CompPartners FINAL REPORT



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO # : _____
MDR #: M2-06-0520-01
Social Security #: XXX-XX-_____
Treating Provider: Joseph Neustein, M.D.
Review: Chart
State: TX
Date Completed: 2/24/06

Review Data:

- **Notification of IRO Assignment dated 1/13/06, 1 page.**
- **Receipt of Request dated 1/3/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 12/5/05, 1 page.**
- **Table of Disputed Services, 1 page.**
- **Provider Federal Tax Identification Number and the License/Certification/Registration Number Request Forms, 1 page.**
- **Correspondence dated 1/11/06, 12/27/05, 5 pages.**
- **Order for Payment of Independent Review Organization Fee dated 1/27/06, 1 page.**
- **Texas Outpatient Non-Authorization Recommendation dated 11/1/05, 3 pages.**
- **Texas Outpatient Reconsideration Decision: Non-Authorization dated 11/21/05, 2 pages.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for a repeat MRI of the left shoulder.

Determination: **UPHELD** - the previously denied request for a repeat MRI of the left shoulder.

Rationale:

Patient's age: Not stated for this review.
Gender: Female
Date of Injury: _____
Mechanism of Injury: Not stated for this review.
Diagnosis: Rotator cuff bursitis.

The records provided for review indicated that this claimant had a reported date of injury in _____, and a diagnosis of rotator cuff bursitis. The treating physician had recommended a repeat MRI, which was denied twice by the insurance carrier. Based solely on the review of the limited information provided for review, the MRI of the right shoulder is not recommended as medically necessary. There was no physician generated documentation provided for review in regards to

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this claimant's medical history, clinical examination findings, current clinical status and course of treatment to date. There was no documentation that there had been a new injury or new or evolving symptoms, with consistent objective examination findings. In the absence of these medical records, the necessity for a repeat shoulder MRI cannot be established.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.
Official Disability Guidelines, Fourth Edition, 2006. p. 1376.

Physician Reviewers Specialty: Orthopedic Surgeon

Physician Reviewers Qualifications: Texas Licensed M.D. and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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.

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