

April 9, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0493-01
TWCC File #:
Injured Employee:
DOI: SS#:
IRO Certificate No.:

Dear :

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

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.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Orthopedic Surgery.

THE PHYSICIAN REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

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 case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, 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. A request for 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 ' 102.4(h)). A request for hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

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 this 9th day of April, 2002.

Sincerely,

Secretary & General Counsel

MEDICAL CASE REVIEW

This is ____, M.D. for ____. I have reviewed the medical information forwarded to me concerning Case File #M2-02-0493-01, in the area of Orthopedic Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Requests for Medical Dispute Resolution, and Responses.
2. Letters from insurance carrier.
3. Letter and medical reports from Dr. M____.
4. Letters and reports from Dr. Joseph N____.

B. SUMMARY OF EVENTS:

An injured employee of ____, reported an injury on ____. Her treating physician is N____, M.D. The insurance carrier is ____.

The proposed health care (surgery) in dispute is Aright rotator cuff decompression surgery.@ Following injury, the patient had physical therapy, nonsteroidal anti-inflammatory medications, muscle relaxants, analgesics, and a TENS unit. Dr. N____ indicates that the patient continues to have limited shoulder movement and strength, and tenderness in the subacromial space.

MRI interpretation by Dr. N____ suggests to him a surgical lesion (impingement) is present, and he requests authorization for arthroscopic decompression of the subacromial space of the right shoulder, and presumably he would inspect the rotator cuff at the same time.

C. OPINION:

1. I AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

2. Surgery authorization was requested and denied in January. The reviewer agreed with the denial in March. Now, more than six months after the injury, the patient's complaints (according to the treating physician) have neither progressed nor improved without surgery.
3. I agree that the shoulder subacromial impingement (even significant tears of the rotator cuff) often is a clinical diagnosis, and MRI is not 100% accurate in detecting impingement or rotator cuff tear. However, there is very little clinical evidence present in Dr. N___s office notes to support an optimistic outcome, that is relief of her shoulder complaint, by arthroscopic surgical decompression of her shoulder.
4. The MRI does not show a tear of tendons of the rotator cuff, nor a significant deformation of the acromion bone, that would irritate the rotator cuff. No other provocative treatment--for example, shoulder bursa injection--was tried.

D. ADDITIONAL COMMENTS:

Injection, a repeat MRI study, re-evaluation of the need for surgery, may be in order at this time, more than three months after the initial injury, with no change in the patient's complaints. There has been no resolution of the associated other chronic complaints, low back, right elbow and wrist discomfort, which were alleged related to the initial injury on _____. It would be appropriate, in my opinion, to have this patient evaluated by a physiatrist and/or pain management physician, and if pain and weakness in the shoulder are found to persist, then it would be appropriate to repeat the MRI study.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____, M.D.

Certified by the American Board of Orthopedic Surgery ____

Date: 8 April 2002