

May 2, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0538-01

IRO Certificate No.: I RO 5055

Dear

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Worker's 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 COMPLETELY 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.

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
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 2nd day of May, 2002.

Sincerely,

Secretary & General Counsel

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning Case File #M2-02-0538-01, in the area of Anesthesiology and Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for pre-authorization dispute over denial of request of arthrogram of the left shoulder with post CT scan.
2. Denial of claim from _____.
3. Designated physician evaluations.
4. History and physical reports.
5. Operative reports.
6. Physical therapy reports.
7. Diagnostic tests.
8. X-ray and MRI reports.
9. Referral claims.
10. Insurance carrier's billing summary.

B. SUMMARY OF EVENTS:

The patient is a 56-year-old male who suffered an injury to the left shoulder on _____. He was subsequently evaluated with an MRI on 2/07/96 which demonstrated a rotator cuff tear. Repair was performed on 9/10/96. Pain and decreased range of motion continued. His complaints extended to the neck. He received neurologic evaluations and had subsequent MRI's of the shoulder and cervical spine. These did not adequately explain the pain and dysfunction. He subsequently had CT scans of the shoulder and C-spine which also did not adequately explain the shoulder and neck pain and probable cervical radiculopathy.

On 5/17/00, _____ performed a debridement and decompression of the left shoulder for "partial rotator cuff tear and shoulder impingement."

The patient first saw _____ on 7/26/99 for pain management and coordinated rehabilitative care. Of note, _____ performed a stellate ganglion block on 12/22/99, without apparent improvement, for a possible early reflex sympathetic dystrophy.

The shoulder and neck radiating pain as well as the associated dysfunction continued. Rehabilitative care and diagnostic studies were continued and repeated. On 12/14/00, the patient's orthopedic surgeon evaluated the patient and made no recommendation regarding the shoulder but continued to note the patient's onset of knee pain a presumed meniscal tear.

On 3/12/01, _____ again recommends stellate blockade for sympathetic dystrophy, but findings are primarily muscle spasms. The findings remain unchanged on 4/02/01 and on 4/23/01, but stellate blocks continue to be recommended.

On 5/14/01, muscle spasms and tenderness were the primary findings. _____, interestingly, noted on 5/14/01 that cardiac evaluation for such a block has been performed, but on 6/11/01 he stated that he continued to wait for such clearance.

On 7/16/01, _____ remained concerned about the reflex sympathetic dystrophy and mentioned the exam is consistent with a sympathetic dystrophy. The exam mentions only muscle spasms and shoulder and neck tenderness.

On 9/10/01, _____ stated that the patient has a reflex sympathetic dystrophy. On 10/29/01, _____ requested an arthrogram of the left shoulder with a post CT scan to assess the "source of the pain." Apparently, the RSD was a lower concern at that time. The stellate block was no longer mentioned on 11/19/01.

On 1/17/02, the patient received an orthopedic evaluation. The exam noted only the muscle spasms along the scapula and paraspinous region. Rehabilitation only was recommended.

On 1/21/02, _____ again concluded that the diagnosis was reflex sympathetic dystrophy and suggested that it was early in the course. The exam noted only the spasms in the posterior cervical area and tenderness of the shoulder and pain on shoulder motion.

On 2/11/02, an arthrogram/CT scan was again requested to evaluate interventional therapy which was unspecified. The exam of 3/04/02 was essentially unchanged.

C. OPINION:

I COMPLETELY AGREE WITH THE DETERMINATION MADE BY THE TEXAS MUTUAL INSURANCE COMPANY UTILIZATION REVIEW.

Specifically, there is no apparent or stated medical information to support the performance of a shoulder arthrogram. No diagnosis is proposed which these studies might identify or eliminate. Similar studies, CT's and MRI's, have already been performed. The shoulder arthroscopy (superior to an arthrogram diagnostically) was done on 5/17/02. Orthopedic exams as recent as 1/17/02 conclude no studies are

necessary for orthopedic care and improvement. There is no stated or apparent pain control modality or treatment that a shoulder arthrogram/CT would bring forth in this case.

IN SUMMARY, the findings and history do not support the requested exams. The medical argument proposed by ___ also is devoid of any specific indication for such an exam.

This patient's pain syndrome is stable. The exams have changed little in over a year. No further credible diagnosis is proposed that might explain or help this patient's circumstance. No support for the medical necessity is brought forth. No intervention of benefit to the patient is described that might follow from such diagnostic studies.

D. ADDITIONAL COMMENTS:

This patient's care has become redundant and poorly organized. He has benefited little from the multitude of interventions. I see little evidence that this patient has a reflex sympathetic dystrophy. Paraspinous tenderness and spasms, coupled with pain on shoulder range of motion, hardly suggest reflex sympathetic dystrophy. This patient's condition is now chronic and fixed.

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.

Date: 1 May 2002