

NOTICE OF INDEPENDENT REVIEW DECISION

January 16, 2003

RE: MDR Tracking #: M2-03-0155-01
IRO Certificate #: IRO 4326

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

___ 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 ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. 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.

Clinical History

This 34 year old female sustained a work-related injury on ___ when she began to experience pain, numbness, and tingling down the upper extremity to the fingers. The patient was evaluated and diagnosed with impingement of the left shoulder, left ulnar neuritis, and rule out herniated cervical disc. An electromyography (EMG) and nerve conduction study indicated carpal tunnel syndrome and the patient underwent a Left Brown procedure on 08/08/01. The patient underwent physical therapy post surgery. An MRI of the left shoulder revealed: bursitis in the subcoracoid, subscapularis-subdeltoid bursa, slight biceps tenosynovitis, and slight increased fluid in the glenohumeral joint consistent with synovitis. In addition it revealed tendinosis and/or tendinopathy of the supraspinatus tendon, with small focus of partial thickness tear involving the inferior or joint side of the TXC tendon. The treating physician has recommended that the patient undergo a left shoulder arthroscopy with decompression.

Requested Service(s)

Left shoulder arthroscopy with decompression.

Decision

It is determined that the left shoulder arthroscopy with decompression is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has a long history of impingement syndrome. The patient's symptoms and findings are consistent with that diagnosis including positive impingement signs, and tenderness over the anterior/lateral corner of the acromion. In addition, the patient has some weakness with testing, some variable decrease in motion (with pain), tenderness over the insertion of the supraspinatus, and pain with supraspinatus resistance test. The x-rays reveal a type II acromion that may be consistent with the diagnosis and the MRI revealed changes that are consistent with the diagnosis. Conservative treatment including non-steroidal anti-inflammatory drugs (NSAID), the use of a TENS units and physical therapy (including phonophoresis, local

ice applications, ultra-sound and a home exercise program) and steroid injections have failed to give significant relief. Due to the extended history of symptoms, the procedure is indicated. Therefore, the left shoulder arthroscopy with decompression is medically necessary to treat this patient's condition.

This decision by the IRO is deemed to be a TWCC decision and order.

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** (10) days of your receipt of this decision (20 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) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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 (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

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 carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 16 th day of January 2003.
--