

May 15, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0950-01

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ 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 on the \_\_\_ external review panel. This physician is board certified in orthopedic surgery. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 51 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she was lifting some boxes weighing 60-70 pounds when she felt sudden left shoulder pain. The patient was initially treated with corticosteroid injections and then left shoulder arthroscopy. The patient reported relief after the surgery, however in 12/01 she reported a return of symptoms. The patient underwent a repeat MRI of the left shoulder and cervical spine. The patient has received additional physical therapy and trigger point injections but the patient still continued to complain of pain. The diagnoses for this patient included residual left shoulder rotator cuff tendonitis, residual impingement, AC strain and anterior labral tear.

### Requested Services

Arthroscopy left shoulder with distal clavicle resection & anterior labral repair.

### Decision

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

### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 51 year-old female who sustained a work related injury to her shoulder on \_\_\_. The \_\_\_ physician also noted that the patient underwent a subacromial decompression, resection distal clavicle and debridement of the joint on 4/19/00. The \_\_\_ physician reviewer further noted that the patient continued to complain of persistent symptoms. The \_\_\_ physician reviewer indicated that the patient underwent an MRI 3/27/02 that showed anterior labral tear.

The \_\_\_ physician reviewer indicated that the patient was evaluated on 3/19/03 and diagnosed with left shoulder rotator cuff tendonitis, residual impingement, AC strain and anterior labral tear. The \_\_\_ physician reviewer explained that the MRI of 3/27/02 is not consistent with a rotator cuff tear, AC OA or impingement. The \_\_\_ physician reviewer also explained that the documentation provided does not support the need for a repeat surgical procedure. Therefore, the \_\_\_ physician consultant concluded that the requested arthroscopy left shoulder with distal clavicle resection & anterior labral repair is not medically necessary to treat this patient's condition at this time.

This decision 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 (ten) 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 15<sup>th</sup> day of May 2003.