

## NOTICE OF INDEPENDENT REVIEW DECISION

July 24, 2003

RE: MDR Tracking #: M2-03-1435-01  
IRO Certificate #: IRO4326

\_\_\_ 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

The patient sustained a repetitive injury to his left shoulder reported on \_\_\_\_. He does overhead assembly line work and noticed increased pain, popping, and grinding when lifting his arms. X-rays dated 11/19/02 revealed supraspinatus tendonitis with fluid, subacromial impingement, acromioclavicular (A-C) joint spurring, and possible rotator cuff tear. Conservative treatments include anti-inflammatory medications, work limitations, physical therapy, and a left shoulder steroid injection.

### Requested Service(s)

Left shoulder arthroscopy with acromioplasty and partial claviclectomy

### Decision

It is determined that the proposed left shoulder arthroscopy with acromioplasty is medically necessary to treat this patient's condition. However, it is determined that the partial claviclectomy is not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The patient was initially seen by the orthopedic provider on \_\_\_\_ which was approximately seven months post-injury. He states the MRI of the left shoulder revealed some fluid about the supraspinatus only very minor changes at the musculotendonous junction. He made a diagnosis of left shoulder impingement with a C-type acromion. A previous MRI dated 11/19/02 stated there were “changes demonstrated with in the rotator cuff tendon without evidence of a partial or full thickness rotator cuff tear”. The patient should be considered for arthroscopic surgical intervention since multiple conservative modalities have been tried including medications, injections, and physical therapy and symptoms persist. Even though the MRI did not show a definitive rotator cuff tear, they have been known to have a 10-15% error rate, especially with rotator cuff injuries.

In regards to the A-C joint, none of the records indicate any definite abnormality and under the physical exam notes, there is no notation to indicate the patient had any tenderness over this joint or pain with adduction of the shoulder to the opposite side. There is no medical indication that would warrant a procedure on the A-C joint. Therefore, It is determined that the proposed left shoulder arthroscopy with acromioplasty is medically necessary to treat this patient’s condition. However, it is determined that the partial claviclectomy is not medically necessary.

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,

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 24<sup>th</sup> day of July 2003.