

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 30, 2003

RE: MDR Tracking #: M2-04-0470-01
IRO Certificate #: 5242

___ 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 an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgeon and has an ADL level 2. The Orthopedic Surgeon 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 claimant has a history of chronic left shoulder pain allegedly related to a compensable work injury on ___.

Requested Service(s)

Left shoulder arthroscopy, acromioplasty, and possible rotator cuff repair.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally the surgical indication for decompression and possible rotator cuff repair includes MRI confirmation of significant anatomical impingement and rotator cuff tendinosis. An MRI report dated 10/19/01 by ___ documents only "mild supraspinatus tendonitis and no geometry of impingement". The claimant has a history of chronic pain syndrome that requires continuous opioid analgesia in the form of Duragesic 75mcg patch (Fentanyl) and use of oral Hydrocodone. Follow up note by ___ indicates that a psychiatric evaluation would "significantly help this patient". There is no radiographic evidence to suggest any significant tendinopathy.

There is no documentation of a psychiatric evaluation as recommended by one of the claimant's treating physicians. There is no documentation of exhaustion of conservative measures of treatment specifically regarding a well structured physical therapy program emphasizing scapular stabilization and home exercise.

I strongly recommend continued conservative management in this clinical setting. I suggest the claimant be fully weaned from narcotic medication prior to any further surgical intervention.

YOUR RIGHT TO REQUEST A HEARING

Either party to 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.