

December 31, 2003

David Martinez
TWCC Medical Dispute Resolution
MS-48
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Austin, TX 78744-1609

MDR Tracking #: M2-04-0575-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ is a 46-year-old gentleman who was working for ___ when he sustained injury to his right shoulder. He was holding a cable and another employee jerked on the cable, causing him to injure his left shoulder. He developed pain and inability to elevate his arm above the shoulder level. He could not use his arm because of pain. He consulted ___, an orthopedic surgeon. He had an MRI of the shoulder and ___ felt that he was a candidate for arthroscopic shoulder surgery.

On July 31, 2002 he performed a shoulder decompression which involved an acromioplasty along with debridement of the subacromial bursa and inspection of the rotator cuff. No tear of the cuff was found. He also did a debridement of the splenoid labrum in the anterior and superior portion of the labrum. He did not do any resection of the distal clavicle.

After surgery, the patient apparently continued to have problems with his shoulder. He went through physical therapy, was supervised in an exercise program, and was seemingly doing very well.

There is one progress note dated January 22, 2003 that states that he was driving his car and was struck on the driver's side, sustaining injury to his shoulder at that time. This record was signed by ____, and he notes that he injected him on that date in order to try to relieve his shoulder after the motor vehicle accident. The reviewer does not know what part the accident has played in the present shoulder symptomatology because it is not mentioned again.

____ continues to have problems with his shoulder and he saw ____, an orthopaedic surgeon, on 10/5/03. This patient was felt to be a candidate for repeat surgery on his shoulder. ____ suggested excision of the distal clavicle and repeat decompression of the shoulder with acromioplasty as indicated. ____, who had taken over treatment of this patient, requested this surgery. The procedure was not approved by the carrier because the surgery had already been done in 2002 and this patient had been declared to be at MMI on ____ by ____.

This patient continues to have painful popping in his shoulder in the vicinity of the acromioclavicular joint. He had a repeat MRI on May 27, 2003 that demonstrated arthritic change in the acromioclavicular joint which could be compatible with symptoms that this patient has been experiencing.

REQUESTED SERVICE

Right shoulder arthroscopy subacromial decompression is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

With regards to this patient's need for the proposed surgery, the reviewer finds that he needs a shoulder decompression which would include resection arthroplasty of the AC joint and acromioplasty as needed. The reviewer agrees with ____ and ____ on this patient's need for surgery due to the fact that this patient is still experiencing symptoms of subacromial impingement syndrome and it appears that he is having impingement at the acromioclavicular joint.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 31st day of December 2003.