

February 4, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0646-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 female who sustained a work related injury on ___. The patient reported that while at work she was attempting to lift a box when she injured her right elbow and right shoulder. The patient was diagnosed with medial and lateral epicondylitis of the right elbow. A MRI of the right elbow dated 10/10/00 was reported as normal and a MRI of the right shoulder dated 10/25/00 indicated a right rotator cuff tear. The patient was also diagnosed with carpal tunnel syndrome on 11/10/00. Initial treatment for this patient's condition included physical therapy. On 6/21/01 the patient underwent a right rotator cuff repair and carpal tunnel release followed by more physical therapy. On 10/23/01 the patient underwent an electromyogram that indicated carpal tunnel syndrome and on 12/18/01 the patient underwent a repeat carpal tunnel release, followed by further physical therapy. A repeat MRI of the right shoulder dated 4/16/02 showed recurrent right rotator cuff tear and the patient underwent a repeat right rotator cuff repair on 5/23/02, followed by physical therapy. A follow up MRI of the right shoulder dated 3/14/03 was reported to show a continued rotator cuff repair and the patient was referred for a third right shoulder repair.

Requested Services

Arthroscopy right shoulder, revision acromioplasty/rotator cuff 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 53 year-old female who sustained a work related injury to her right shoulder on ___. The ___ physician reviewer indicated that the patient reportedly sustained a full thickness tear of the right rotator cuff and complains of ongoing pain. The ___ physician reviewer noted that on 6/21/01 the patient underwent rotator cuff repair surgery and that on

5/23/02 the patient underwent repeat rotator cuff repair surgery. The ___ physician reviewer further noted that the patient is being referred for a third repair surgery. The ___ physician reviewer explained that a chronic, potentially irreparable tear may not be amenable to repair, nor is repair necessarily critical to the patient's outcome. The ___ physician reviewer explained that in this patient's case, it is unlikely that the rotator cuff tear is repairable and unlikely that an acromial or CA ligament related impingement persists. The ___ physician reviewer indicated that the progress notes provided do not address whether this patient experiences clinical weakness or described diminished pain after a subacromial lidocaine injection. The ___ physician explained that although an MRI showed a rotator cuff tear, this is not an indicator that surgery is medically necessary. The ___ physician reviewer also explained that the documentation provided did not contain a physical exam that would indicate the source of this patient's pain. The ___ physician reviewer further explained that the possibility of the biceps tendon being involved or the possibility of the rotator cuff tear being the source of this patient's pain has not been determined. Therefore, the ___ physician consultant concluded that the requested arthroscopy of the right shoulder, revision acromioplasty/rotator cuff 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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 4th day of February 2004.