

April 5, 2004

MDR Tracking #: M2-04-0934-01

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 board certified and specialized 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 50-year-old man who sustained injury to his shoulder while he was working on ___. This was specifically an injury to the left shoulder when he was lifting a heavy moulding. He felt a painful pop in the shoulder and he could not go further with the lifting because of pain. He had continued symptoms of pain in the shoulder, with inability to elevate his arm above the shoulder level. His pain was located in the subacromial area. He also had neck pain and pain radiating down from his neck. He was worked up for his problems and was found to have neck problems and well as shoulder pain.

The shoulder is still symptomatic and he has had several injections in the shoulder that have not helped. He has painful crepitation on abduction of the shoulder. He has palpable scapulothoracic crepitation. He has seen ___, a shoulder specialist in ___. ___ has suggested a superior pole scapulectomy to relieve the scapulothoracic crepitating and bursitis. In addition, he has been found to have a small rotator cuff tear and subacromial impingement and ___ has suggested a rotator cuff repair with shoulder decompression that would consist of acromioplasty and excision of the distal clavicle.

REQUESTED SERVICE

Left shoulder arthroscopy, acromioplasty, excision distal clavical and superior pole scapulectomy are requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer agrees that the record supports the need for the surgery that has been suggested. This patient is having scapulothoracic pain from crepitation and a superior pole scapulectomy is the procedure of choice for that particular problem. In addition, the patient has MRI evidence of rotator cuff tear and is having signs and symptoms of subacromial impingement syndrome with impingement related to acromioclavicular joint enlargement. The proposed procedure is correct. He should have an acromioplasty, rotator cuff repair and excision of the distal clavicle to correct that particular problem. In summary, the reviewer agrees with ____.

____ 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.

<p>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 5th day of April 2004.</p>
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