

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 19, 2004

RE: MDR Tracking #: M2-04-0959-01

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 reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. 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 claimant is a 58 year old female with complaints of shoulder, neck and elbow pain on left after work injury dated ___. Onset of pain occurred while using sewing machine which she had used for 10 years. She received extensive physical therapy over almost one year. Her shoulder was injected with temporary pain relief and improved motion. She had an MRI in April 2003 which indicated a small full thickness tear of the supraspinatus tendon with minimal displacement. Orthopaedic consultant noted supraspinatus weakness, positive impingement and minimal anterior deltoid atrophy. Diagnosis of adhesive capsulitis and rotator cuff tear was made and surgery was recommended.

Requested Service(s)

Manipulation, rotator cuff repair, acromioplasty and partial clavicle resection (Mumford Procedure)

Decision

I disagree with the insurance carrier and find that the services in dispute were medically necessary.

Rationale/Basis for Decision

Indications for rotator cuff surgery include finding of pain and weakness in the shoulder with limited motion and positive impingement. Diagnostic studies (MRI) documented a full thickness supraspinatus tear which is compatible with her presenting history and physical findings.

The recommended treatment in the above situation would be 4-6 months conservative and if pain and weakness persist, rotator cuff repair is indicated. In this particular case I doubt significant adhesive capsulitis, and would recommend exam under anesthesia rather than manipulation. The acromioplasty would be included in the rotator cuff repair procedure, the clavicle procedure would be an additional CPT code.

Reference: AAOS website under Orthopaedic Knowledge Update: Rotator Cuff Tears- Evan Flatow, MD, also consult Campbell's Operative Orthopaedics.

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) 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.