

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 14, 2004

Re: IRO Case # M2-04-1204-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Letter of medical necessity 3/5/04
3. Summary of carrier's position 4/14/04
4. Peer review 1/24/04
5. Notes from requesting surgeon
6. Physical performance evaluation 1/29/04
7. MRI right shoulder report 8/5/03
8. Pain management new patient report 3/25/04
9. TWCC 69 10/14/03 Designated doctor evaluation

10. Notes from first orthopedist
11. Letter dated 4/27/04 and records from claims administrator beginning with Employers first report of injury 5/22/03 through Letter of medical necessity 2/16/04
12. Rehabilitation notes
13. Physical therapy notes

History

The patient suffered a right shoulder injury secondary to repetitive activities. She developed right shoulder pain and sought medical help in _____. She was diagnosed with a sprain and was prescribed physical therapy for a two-week period. The patient was referred to an orthopedic surgeon who suspected subacromial impingement and ordered an MRI. The MRI showed partial articular surface tear of the rotator cuff, and supraspinatus and infraspinatus tendonitis. The patient eventually sought other care, and was referred to another orthopedic surgeon. The new surgeon recommended arthroscopic decompression with distal clavicle excision.

Requested Service(s)

Arthroscopy with subacromial decompression

Decision

I disagree with the carrier's decision to deny the proposed surgery.

Rationale

The medical records reveal that the patient has a plausible history consistent with repetitive overhead activities causing subacromial impingement and rotator cuff tendonitis. The date that the patient remembers was probably the date on which she suffered a partial rotator cuff tear, which perpetuated her shoulder pain. The patient has not responded well to greater than nine months of physical therapy measures, and she certainly is a candidate for outpatient arthroscopic surgery and decompression as well as distal clavicle excision.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

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.

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 18th day of May 2004.