

May 19, 2004

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MDR Tracking #: M2-04-1257-01
IRO #: 5284

___ 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.

This case was reviewed by a licensed Medical Doctor who is board certified in Orthopedic Surgery. 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 60 year old male employed as a bus operator with ___. He was injured on ___ when the door to a tool shed blew open and struck him in the face, cracking his tooth, which caused him to fall backwards into the shed landing on his buttocks and sacral area. As he fell backwards, he stretched out both of his upper extremities and landed on his left arm and wrist. He was also struck by a metal object that fell down on top of him. He was able to stand up after the accident and continued to work his route. ___ notified his supervisor and when he arrived to his final destination, he was sent to the emergency room at ___. Records state that x-rays were obtained of his left wrist and it was determined that there was no fracture. He was given a bandage for the wrist as well as Motrin. Initial referrals were to ___ and ___. ___ has a significant past medical history of open-heart surgery, stroke, cholecystectomy, hypertension and obesity and suffered a previous left shoulder injury in 1975.

1. The first evaluation was performed by ____, on 07-15-03. The patient was complaining of left wrist pain, back pain and there was no mention of any shoulder problem. The impression was a left wrist injury and a lumbar spine sprain/strain and the recommendation was to refer the patient to ____ for conservative treatment.
2. The next evaluation was performed by ____ from 07-22-03 through 08-26-03. Again, there was no mention of left shoulder problems or injury and the diagnosis of a non-displaced and impacted distal fracture was made based upon plain film and bone scan images.
3. On 08-07-03, the patient was evaluated by ____ and again comments were made regarding the left distal radius. The dates for ____ were 07-03-03 and 08-07-03.
4. The first mention in this review of any problems with the left shoulder was on 07-18-03 from _____. Initial examination by ____ was on 7-18-03 and the claimant complained of left wrist, low back and neck pain. During the examination, the left shoulder was noted to have limited range of motion as well as anterior shoulder pain. No specific shoulder maneuvers were performed and there was no shoulder pain identified in the note. Subsequent follow up examinations by ____ were through 04-22-04 and numerous references to left shoulder and acromioclavicular joint pain were made, as well as limited range of motion.
5. On 08-12-03, the patient was evaluated by ____ and complained of shoulder pain and the records reflect a limited range of motion in the left shoulder compared to the right. There was acromioclavicular joint pain. However, no provocative or specific objective test for impingement or acromioclavicular joint problems or rotator cuff problems were mentioned in this report. The recommendation of ____ was physical therapy, to discontinue the left wrist splint and to order an MRI of the left shoulder. A subsequent handwritten note from the office of ____ was reviewed on 10-23-03 stating that the patient has left shoulder pain at night.

REQUESTED SERVICE

The disputed service is the prospective medical necessity of proposed modified Mumford procedure to the left shoulder to be performed at ____ by ____.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The decision is based upon the accepted treatment guidelines and care standards for management of rotator cuff and distal clavicular problems. The records do not support the requested modified distal clavicular excision procedure. The last note by ____ on 8/12/03 did not describe sufficiently the objective or subjective findings which would necessitate such a procedure. The recommendations at that time were for physical therapy of the wrist and an MRI of the shoulder. According to the records provided, no further orthopedic examination have been performed subsequent to this date.

Therefore, the reviewer cannot support such a procedure.

___ 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 this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

Sincerely,

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 19th day of May 2004