

## NOTICE OF INDEPENDENT REVIEW DECISION

June 3, 2004

MDR Tracking #: M2-04-1273-01

IRO Certificate #: IRO4326

The \_\_\_ 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 a \_\_\_ physician reviewer who is board certified in Orthopedic Surgery, by the \_\_\_ licensed by the Texas State Board of Medical Examiners (TSBME) in \_\_\_, and who provides health care to injured workers. This is the same specialty as the treating physician. 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

This 37-year-old female began experiencing numbness and coldness to her right upper extremities into her fingers \_\_\_. On 4/17/03 she was diagnosed with mild carpal tunnel syndrome, rotator cuff syndrome in her right shoulder, and ulnar neuritis. Treatment included 2-cortisone injections to her right shoulder and 1 cortisone injection to her right elbow. She has also been treated with physical therapy, home exercise program, and pain medications. Her doctor is requesting a right shoulder debridement and decompression.

### Requested Service(s)

Right shoulder debridement and decompression

### Decision

It is determined that the right shoulder debridement and decompression is medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

Impingement syndrome is the diagnosis. In this condition, the subacromial bursa is chronically inflamed due to persistent irritation between the coracoid/acromioclavicular joint

above and the head of the humerus below. Conservative treatment consists of physical therapy and injections to relieve the inflammation in the bursa. The therapy is designed pull the humerus down (inferior) by stretching the capsule, and then, strengthening of the cuff muscle. This program has apparently failed.

The proposed surgery is arthroscopic. It involves removing the subacromial bursa and trimming the bone from beneath the coracoid/AC joint. This surgery is successful in a high percentage of cases. The rehabilitation is very important (to resist any capsular contractures bringing the humeral head too close to the acromion and supraspinatus tendon). Therefore, the proposed right shoulder debridement and decompression is medically necessary.

This decision by the IRO 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) 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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), 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 3 <sup>rd</sup> day of June 2004.
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