

July 27, 2004

MDR Tracking #: M2-04-1360-01
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 Orthopedic 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 69-year-old woman who originally injured her left shoulder in a work-related injury on ___ while employed for ___. It is noted she slipped on a wet floor and landed on her outstretched arm.

She suffers persistent left shoulder pain and eventually underwent an arthroscopic subacromial decompression and debridement of a partial rotator cuff tear performed by ___ on December 31, 2002.

She had persistent pain in the left upper extremity and eventually underwent a carpal tunnel release performed by ___ on April 21, 2003. However, this did to decrease her symptoms.

On March 6, 2003 ___ saw this patient and opined that she had a probable rotator cuff tear of the left shoulder. The patient underwent an exhaustive work-up to include a CT arthrogram of the left shoulder, which demonstrated a large rotator cuff tear of that left shoulder. ___ spoke to ___ by telephone to discuss the original surgery.

___ eventually underwent an arthroscopy of the left shoulder with chondroplasty and subacromial lysis of adhesions by ___ on October 1, 2003. The rotator cuff tear was seen at that time but for some reason was not repaired.

On January 19, 2004 ___ recommended a rotator cuff repair. On April 15, 2004 it is noted that the surgery was denied.

REQUESTED SERVICE

Left shoulder arthroscopy and rotator cuff repair with possible open procedure with usage of an airplane splint 98 are requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

___ is a 69-year-old woman with a left shoulder rotator cuff tear. She was having persistent pain consistent with rotator cuff tear.

Based on the above-mentioned information, the reviewer finds that the request of a left shoulder arthroscopy with a rotator cuff via open or through a mini-arthrotomy with use of an airplane splint 98 would be reasonable and necessary to treat this patient.

Please note that this patient has persistent pain consistent with a rotator cuff tear. The rotator cuff tear has been identified by arthroscopy. The requested procedure is reasonable and necessary.

___ 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 ___, Inc, dba ___, 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.

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 28th day of July, 2004.