

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** August 4, 2004

**MDR Tracking #:** M2-04-1557-01

**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 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.

### **Records submitted by carrier:**

- IRO Paperwork
- Table of disputed services
- Pre-authorization decision
- Notes by \_\_\_
- Chart review by \_\_\_
- Notes by \_\_\_
- MRI Left shoulder

### **Records submitted by provider:**

- Notes by \_\_\_

### **Clinical History**

On 3/24/04, \_\_\_ noted the patient incurred injury on \_\_\_ while lifting a heavy box and developed severe pain in his left shoulder that radiated to the left upper arm. \_\_\_ noted the patient had one previous trigger point injection in the left upper arm, but not in the subacromial space or the acromioclavicular joint. On 6/26/03, MRI of the left shoulder showed no evidence of full or partial thickness tear of the rotator cuff. There is patchy moderate degeneration in the supraspinatus tendon consistent with tendinosis. There is combined lateral downward angulation and acromion process and thickening of the acromioclavicular ligament. There is mild acromioclavicular joint degenerative arthropathy. On 3/24/04, \_\_\_ performed a subacromial injection and recommended manipulation under anesthesia.

On 4/15/04 the physician assistant for \_\_\_ recommended an MRI arthrogram to further delineate the rotator cuff. On 5/17/04, \_\_\_ recommended left shoulder arthroscopy and subacromial decompression.

**Requested Service(s)**

Please address the medical necessity for the proposed left shoulder arthroscopy, debridement and acromioplasty.

**Decision**

I agree with the carrier. The left shoulder arthroscopy, debridement and acromioplasty are not medically necessary.

**Rationale/Basis for Decision**

The patient has not had a full adequate work-up. There is poor documentation from the providers with regards to the evaluation of the left shoulder pain. The patient has not had documentation as to the relief of injections into the subacromial space. The patient has not had acromioclavicular injections. The diagnostic injections can serve to further delineate the source for the patient's symptoms. If the patient has relief of symptoms following a subacromial injection, then surgical treatment can be directed towards decompression of the subacromial space. If the patient has relief of symptoms from the left shoulder clinical injections, the patient would then be a candidate for the proposed procedure. As a result, further diagnostic injections would be warranted to better delineate the patient's source of focal pathology prior to surgical treatment.

**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.

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organizatoin (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this day 4<sup>th</sup> day of August 2004.