

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 10, 2004

RE: MDR Tracking #: M2-04-1566-01
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.

Submitted by Requestor:

- EMG, 11/25/03
- ___ and ___, treatment notes, 01/28/04-04/07/04

Submitted by Respondent:

- RMEs, 12/11/03 and 02/03/04
- Consultation notes, ___, 09/08/03
- ___, 09/27/03
- ___, 10/23/03
- ___, 11/04/03
- ___, 11/25/03
- ___, 01/28/04
- ___, 03/29/04
- Physical therapy visits, (92 total), 09/08/03-06/23/04
- FCEs, 12/10/03, 01/12/04, 04/27/04
- EMG/NCV 11/25/03
- Xrays forearm and wrist, 09/08/03
- MRI shoulder and wrist, 10/23/03

Clinical History

On ____, the patient was working as a ____ at ____ when she was doing repetitive activities and had discomfort in her right shoulder. On 9/8/03, ____, pain management, saw the patient for her right shoulder pain and right wrist pain. On 9/16/03, the patient reported improving symptoms in her wrist, but continued pain in her right shoulder. ____ treated the patient with therapy, activity modification and Skelaxin. On 10/23/03, MRI of the right wrist showed extensor tenosynovitis involving the extensor carpi radialis and extensor digitorum with minimal fluid in the distal radial joint. The fluid in the distal radial joint was suggestive of triangular fibrocartilage complex tear. There was no evidence of bone marrow contusion or fracture. On 10/23/03, MRI of the right shoulder showed Type II acromion with down slope producing lateral outlet narrowing. There was tendinopathy of the rotator cuff with no evidence of full thickness tear. The bicipital labral complex was normal. On 11/4/03, ____ saw the patient for her right shoulder pain. On 11/25/03, EMG/NCV studies showed no evidence of right upper extremity neuropathic process. On 11/9/03, ____ felt the patient had no explainable pathology at the shoulder or the wrist. She additionally underwent a work hardening program and functional capacity evaluation. On 1/9/04, the patient had a subacromial injection. On 1/23/04, ____ noted the patient did not get relief with this subacromial injection. The patient had pain in the shoulder posteriorly and radiating down into her arm. ____ felt that given that subacromial injection did not give her relief, he did not have anything to offer the patient. On 1/28/04, the patient changed her treating physician to ____ who treated the patient with a brace for her wrist and a carpal tunnel injection on 2/18/04. On 2/20/04, ____ performed first dorsal compartment injection for de Quervain's tenosynovitis. On 3/29/04, ____ saw the patient and noted from the MRI a partial rotator cuff and recommended surgery given the patient had not responded to subacromial injection. ____ recommended arthroscopic resection of partial rotator cuff tear and subacromial injection. There were no clinical exams by ____.

Requested Service(s)

Arthroscopic decompression of the right shoulder and resection of partial rotator cuff and labrum tear.

Decision

I agree with the carrier that the requested services are not medically reasonable or necessary.

Rationale/Basis for Decision

The patient has right shoulder pain. Her clinical examination and imaging studies do not show focal pathology. The negative response to diagnostic injections has not confirmed focal pathology to be addressed surgically. The patient is not a candidate for surgery. ____ has not documented a good clinical examination of her right shoulder. The MRI of the right shoulder showed no evidence of rotator cuff tear. The diagnostic subacromial injections did not give her relief of her symptoms. As a result, given inadequate clinical examinations, MRI of the shoulder without focal pathology, and non-response to diagnostic injections, the patient is not a candidate for the proposed procedure.

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 Organization (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 10th day of August 2004.