

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** August 10, 2004

**AMENDED DECISION**

**MDR Tracking #:** M2-04-1604-01

**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 Supplied by Carrier**

- IRO Paperwork
- Pre-authorization decision and appeal decision
- RME, \_\_\_, 6/30/03

### **Records Supplied by Provider**

- Notes by \_\_\_
- Shoulder MRI, 7/14/99
- Notes by someone with initial RDP
- RME, \_\_\_, 6/7/02
- FCE 11/30/99
- Notes, \_\_\_
- Shoulder MRI, 4/20/04
- Notes, \_\_\_
- Notes from claimant
- RME, \_\_\_, 6/30/03
- TWCC-69 and Impairment rating, 2/2/00

### **Clinical History**

The patient incurred injury on \_\_\_ following repetitive use causing her left shoulder pain. The patient had a long course of non-operative treatments with oral medications, therapy and subacromial injections. On 4/20/04, MRI of the left shoulder showed widening of the acromioclavicular joint with degenerative arthritis. There is tendinopathy at the supraspinatus tendon. There is no evidence of rotator cuff tear or labral tear. The biceps tendon is not torn. On clinical examination on 4/5/04, \_\_\_ noted that the patient had acromioclavicular joint tenderness with positive near impingement sign, and x-rays showed a Type III acromion. \_\_\_ felt the patient to have left shoulder impingement, left shoulder acromioclavicular joint injury and left shoulder mild anterior instability. On previous work-up on 6/24/03, \_\_\_ treated the patient and felt the patient to be a candidate for arthroscopic decompression of the subacromial space.

### **Requested Service(s)**

Please address the medical necessity of arthroscopy, partial claviclectomy and capsular contracture release.

### **Decision**

I partially agree with the insurance carrier that some of the requested services are not medically necessary.

I feel that the left shoulder arthroscopy and subacromial decompression and distal clavicle debridement is medically necessary and reasonable.

I feel that the capsular shift or capsular contracture release is not indicated and is not medically necessary or reasonable.

### **Rationale/Basis for Decision**

The patient has had a prolonged course of non-operative treatments from the date of injury on \_\_\_ through the last clinic note on 5/18/04. The patient has had only temporary relief of her symptoms with non-operative treatments to include oral medications, therapy and subacromial injections. Her clinical examination is positive for acromioclavicular joint pain and positive Neer impingement test. The patient, however, mainly complains of pain and no symptoms of instability. As a result, I find that giving her a prolonged course of non-operative treatment giving her only temporary relief of symptoms, the patient is a candidate for subacromial arthroscopy and subacromial decompression and distal clavicle resection. However, the patient is not a candidate for capsular shift, given that she does not have symptoms of instability. Thus, this is a partial agreement with the proposed procedure of left shoulder arthroscopy and subacromial decompression and distal clavicle debridement. However, again, given the patient has no symptoms of instability, the capsular shift or capsular contracture release is not indicated.

## **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.