

October 24, 2004

MDR Tracking #: M2-05-0037-01

IRO Certificate #: 5284

___ 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.

This case was reviewed by a licensed Doctor of Osteopathy who is board certified in Physical Medicine and Rehabilitation. The reviewer is on the TWCC 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

This is a 57 year old female who sustained an injury to her left shoulder while at work. An MRI of the left shoulder revealed a contusion to the deltoid area, small partial tear of the articular surf and surface of the distal and supraspinatus tendon with possible mild impingement of the supraspinatus tendon. She was treated conservatively and did not improve. She ended up having surgery on 8-5-04 by ___. She had arthroscopic glenohumeral debridement with arthroscopic excision of the distal clavicle and arthroscopic acromioplasty. A four week rental on a shoulder CMP cryotherapy unit and two month rental of a Smartwave GS200 neuromuscular stimulator unit were recommended.

REQUESTED SERVICE

The items in dispute are the prospective medical necessity of a 4 week rental on a shoulder CPM Cryotherapy Unit and a 2 month rental on a Smartwave GS200 Neuromuscular Stimulator Unit.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The mainstay of treatment after shoulder surgery is rehabilitation. Rehabilitation consists of two phases; stretching exercises restore range of motion and strengthening exercises improve muscle power. This should be performed by a physical therapist. There is no medical need for the shoulder CMP cryotherapy unit and Smartwave GS200.

References:

1. "Essential of Musculoskeletal Care", Walter Greene, Editor, Page 153.
2. "Clinical Evidence", Issue 6, published by United Health Foundation. There was no evidence found of significant effect for electrotherapy versus placebo and they found no significant difference in the recovery period at four weeks.
3. "Clinical Evidence", Issue 6, published by United Health Foundation. There was insufficient evidence for the effects of ice.

___ 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. ___ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, 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.

Sincerely,

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.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

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 24th day of October, 2004