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NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 25, 2005

Requester/ Respondent Address:

TWCC
Attention: ____
7551 Metro Center Drive, Suite 100, MS-48
Austin TX 78744-1609

Stephen S Burkhart, MD
Attn: Mary Hatter
Fax: 210-402-6257
Phone: 210-489-7220

Pacific Employers Insurance Co c/o ESIS
Attn: Alvera Butler
Fax: 713-403-3139
Phone: 713-403-3297

RE: Injured Worker:

MDR Tracking #: M2-05-0612-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 Requester:

- Notes and letter from Stephen Burkhart, M.D.
- Notes from Dr. Deetjen
- MRI report dated 5/15/03
- MRI report 10/20/04

Submitted by Respondent:

- Notes from Dr. Burkhart
- Notes from occupational therapy
- MRI report dated 5/15/03
- Note from Dr. Deetjen

Clinical History

___ sustained a work related injury to his right shoulder on ___ while throwing chains over his truck to secure his load. He did not improve with conservative treatment. He was seen by Dr. Burkhart and he noted the MRI of 5/15/03 did not show a rotator cuff tear, however, ___'s examination was consistent with a superior labrum anterior-posterior (SLAP) lesion. On 10/13/03, ___ had arthroscopy of his shoulder and had repair of a SLAP lesion and a partial tear of the supraspinatus tendon. Following surgery, he underwent therapy to restore motion and strength. He had a persistent limitation of external rotation, only reaching 40°. He had minimal limitation of abduction and internal rotation. On 8/17/04 he was released to work with a 6 week restriction not to throw chains over his load. He began throwing chains on 9/13/04 and was seen on 9/21/04 with a complaint of sudden shoulder pain that occurred when he was pushing up the binder on one of his chains. On 10/20/04 an MRI demonstrated the shoulder repairs were intact.

Requested Service(s)

Arthroscopic acromioplasty and capsular release

Decision

I disagree with the insurance carrier and find this procedure is medically necessary.

Rationale/Basis for Decision

This is a man who had a successful repair of a SLAP lesion and partial supraspinatus tear; however, he never achieved full motion post surgery. His external rotation was markedly limited at 40°. His recurrent problem was within reasonable medical probability related to post-operative adhesions preventing external rotation. Arthroscopic capsular release would be the recommended remedy for this situation. This should be followed by an aggressive therapy program to maintain shoulder motion and improve rotator strength.

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 25th day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder