

# Parker Healthcare Management Organization, Inc.

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Certificate # 5301

June 1, 2005

**ATTN: Program Administrator**  
**Texas Workers Compensation Commission**  
Medical Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744  
Delivered by fax: 512.804.4868

## Notice of Determination

MDR TRACKING NUMBER: M2-05-1302-01  
RE: Independent review for \_\_\_\_

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 4.26.05.
- Faxed request for provider records made on 4.26.05.
- The case was assigned to a reviewer on 5.15.05.
- The reviewer rendered a determination on 5.31.05.
- The Notice of Determination was sent on 6.1.05.

The findings of the independent review are as follows:

### Summary of Clinical History

Mr. \_\_\_\_ sustained a work related injury \_\_\_\_, while employed at Commercial Metals, Co. Since the injury, the patient has had ongoing shoulder pain.

### Questions for Review

Medical necessity of the proposed ASC care, right shoulder arthroscopy, subacromial decompression, distal clavicle excision and rotator cuff repair

### Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial**.

### Clinical Rationale

The review documents include a history and physical dated December 4, 2003 completed by Miguel A. Berastain, M.D., PA. This document identifies the patient's injury as a torn right rotator cuff and recommends an MRI. An MRI of the right shoulder, dated 12.9.03, shows a full thickness tear involving the supraspinatus tendon with evidence of approximately 2 cm retraction. A physical and history exam performed on 12.16.04 from Charles W. Breckenridge, M.D., shows an assessment of a right shoulder

rotator cuff tear with impingement syndrome, acromioclavicular joint hypertrophy with internal derangement creating impingement. Dr. Breckenridge recommends proceeding with an arthroscopic procedure to repair the rotator cuff. The history and physical exam dated 4.29.04 from Stephen S. Burkhart, M.D. stated the impression was a large recurrent rotator cuff tear, left shoulder (probable dictation error since the documentation identifies the right shoulder as the area for examination). Dr. Burkhart noted agreement to proceed with the arthroscopic subacromial decompression and rotator cuff tear repair.

Preauthorization for these procedures have been denied based upon lack of conservative care. It is not my opinion that conservative care is indicated under these circumstances, unless the patient has refused surgical intervention or is not medically or mentally qualified for the procedure. The recommended optimal treatment for patients with complete rotator cuff tears, who are mentally and physically qualified candidates, is surgical intervention to repair the tear. Typically, this includes a subacromial decompression or acromioplasty and excision of the distal clavicle (if indicated at the time of surgery) as well as a rotator cuff repair. An arthroscopic procedure is indicated to evaluate the glenohumeral joint and debride the glenohumeral joint, if indicated and treat identified lesions, if indicated and subsequently facilitate the performance of the other indicated procedures, if possible. Non-operative treatment is considered indicated when the patient is a poor candidate for surgery or otherwise refuses surgical intervention. There is nothing in the records provided which has suggested the patient is a poor candidate for surgery or otherwise refused surgical intervention. Therefore, the proposed ASC care, right shoulder arthroscopy, subacromial decompression, distal clavicle excision and rotator cuff repair seems to be medically appropriate care.

## Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 15 years of patient care and orthopedic surgery.

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The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is a diplomate of the *American Board of Orthopedic Surgery*, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

### 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. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk 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 and the first working

day after the date this Decision was placed in the carrier representative's box (28 Tex. Admin. Code § 102.5 (d)). A request for hearing should be sent to: Chief Clerk of Proceeding/Appeals , P.O. Box 17787, Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of this written request for a hearing to the opposing party involved in the dispute.

I hereby verify that a copy of this Findings and Decision was faxed to TWCC, Medical Dispute Resolution department, the requestor (if different from the patient) and the respondent. I hereby verify that a copy of this Findings and Decision was mailed to the injured worker (the requestor) applicable to Commission Rule 102.5 this 1st day of June, 2005. Per Commission Rule 102.5(d), the date received is deemed to be 5 (five) days from the date mailed and the first working day after the date this Decision was placed in the carrier representative's box.

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Meredith Thomas, IRO Administrator

CC:

[Claimant]

ESIS  
Attn: Alvera Butler  
Fax: 713.403.3139