

IRO America Inc.

An Independent Review Organization

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April 5, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____

TDI-DWC #: _____

MDR Tracking #: _____

M2-06-0796-01

IRO #:

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed MD, board certified and specialized in Orthopedic Surgery. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

- Office Notes, Dr. Chavda, 10/25/04, 10/29/04, 11/10/04, 11/24/04, 02/07/05, 06/15/05, 10/05/05, 11/04/05, 12/05/05, 12/21/05, 01/06/06, 01/20/06, 01/25/06, 01/30/06, 02/01/06, 02/13/06
- Operative report, Dr. Chavda, 02/22/05
- Utilization review, Dr. Buczek, 12/29/05

- Letter of appeal, Dr. Chavda, 01/11/06, 01/25/06
- Utilization review, Dr. Garcia, 01/16/06

CLINICAL HISTORY

This Patient ___ was involved in a motor vehicle accident on _____ that resulted in cervical, lumbar and bilateral shoulder pain. Following the injury, The Patient underwent extensive treatment with Dr. Chavda for the neck, back and both shoulders. According to Dr. Chavda's office note of 11/24/04 an MRI of the left shoulder was done on 11/18/04 and showed tendinopathy of the mid supraspinatus tendon. There was no evidence of a full thickness rotator cuff tear. There was subacromial bursitis with subacute arthritic changes of the AC joint. There was thinning of the labral cartilage indicating degenerative change. A left shoulder steroid injection was provided at that visit.

The Patient continued to treat with Dr. Chavda for cervical and lumbar pain and bilateral shoulder pain. He underwent right shoulder surgery on 02/22/05. On 06/15/05 Dr. Chavda documented increased pain of the left shoulder with overhead activity. On examination The Patient had positive AC joint tenderness and decreased range of motion on internal rotation. Impingement test was negative and there was minimal rotator cuff weakness clinically. The diagnosis was left shoulder type II acromion and AC joint impingement with minimal rotator cuff weakness clinically. The physician recommended open decompression and repair of the partial rotator cuff tear.

The records lapse between 07/07/05 and 10/05/05. The Patient underwent lumbar surgery on 11/4/05. On 12/5/05 Dr. Chavda documented positive AC joint tenderness, decreased internal rotation, negative impingement test and minimal rotator cuff weakness clinically. The physician requested left shoulder open decompression, distal clavicle resection/Mumford and rotator cuff repair. The Patient was taking Celebrex and Vicodin. On 12/21/05 The Patient had left shoulder positive AC joint impingement, abduction to 140 degrees and forward flexion to 150 degrees and decreased internal rotation and external rotation and rotator cuff weakness.

A utilization review dated 12/29/05 denied the surgical procedure due to lack of documentation of conservative treatment. A letter of appeal from Dr. Chavda dated 01/11/06 noted that The Patient had several months of physical therapy for his multiple body parts including the left shoulder and noted that he had received a steroid injection on 11/24/04 that did not provide any relief. Dr. Chavda also indicated in this letter that the left shoulder surgery was approved in June 2005 but was canceled due to The Patient's lumbar spine pain which was more significant at the time.

A second utilization review dated 01/16/06 by Dr. Garcia also denied the left shoulder surgery. Dr. Garcia spoke with Dr. Chavda but noted that the MRI did not show a full thickness tear and the physical exam of 12/05/05 did not support a full thickness tear or the need for surgical treatment as The Patient had decreased range of motion with internal rotation only, a negative impingement sign and minimal rotator cuff weakness.

On 01/20/06 Dr. Chavda noted that the left shoulder had positive AC joint impingement, 120 degrees of abduction and forward flexion, positive drop can test and significantly decreased internal and external rotation. There was significant rotator cuff weakness, left worse than right. The diagnosis was left shoulder type II acromion, AC joint impingement with minimal rotator cuff weakness clinically and left shoulder surgery was recommended.

Dr. Chavda authored a second letter of appeal dated 01/25/06. At the 02/01/06 visit, left shoulder exam findings were unchanged. X-ray of the left shoulder on 02/01/06 showed a type II acromion and inferior spurring about the AC joint. The diagnosis and surgical recommendation remained unchanged.

DISPUTED SERVICE(S)

Under dispute is the prospective, and/or concurrent medical necessity of shoulder decompression/distal clavicle resection /rotator cuff repair.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

The Reviewer recommends approval of the shoulder arthroscopy with decompression and distal clavicle resection as being medically necessary. The Patient has MRI evidence of significant tendinosis. He has had extensive conservative treatment including physical therapy, injections, nonsteroidal anti-inflammatory medications and The Patient persists with impingement complaints at the acromioclavicular joint and weakness of the shoulder and has not improved with conservative treatment over a long period of time. His examination findings are consistent throughout the records. Impingement syndrome usually responds well to surgical intervention when conservative therapies have failed. Based on the fact that The Patient has signs and symptoms that are consistent with his MRI findings and he has failed to improve with conservative treatment the proposed arthroscopic surgery of the shoulder is reasonable and appropriate.

Screening Criteria

1. Specific:

- ODG Treatment in Workers' Comp, 4th edition, 2006, pages 1383-1384

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolution Officer

Cc: _____

Old Republic Ins. / ECAS
Attn: Neal Morelan
Fax: 512-732-2404

Deepak Chavda
Fax: 817-485-2212

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or The Patient's representative) and the DWC via facsimile, U.S. Postal Service or both on this 5th day of April, 2006.

Name and Signature of IRO America Representative:

Sincerely
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolution Officer