



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M2-06-0411-01
NAME OF REQUESTOR: Orthopaedic Associates of North Texas
NAME OF PROVIDER: Michael Adams, M.D.
REVIEWED BY: Board Certified in Orthopedic Surgery
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 12/14/05

Dear Orthopaedic Associates of North Texas:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Orthopedic Surgery and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known

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conflicts of interest that exist between him the provider, 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 carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An evaluation with Michael Adams, M.D. dated 09/16/05

An MRI of the right shoulder dated 10/06/05 and interpreted by Evan L. Cohn, M.D.

Another evaluation with Dr. Adams dated 10/19/05

A preauthorization notice from Corvel dated 10/27/05

Another preauthorization determination from Corvel dated 10/28/05

A summary in response to the IRO request dated 11/22/05 from Jane Peizl, R.N. at Corvel

A summary of the carrier's position dated 11/28/05 from Steven M. Tipton at Flahive, Ogden, & Latson

Clinical History Summarized:

Dr. Adams evaluated the patient on 09/16/05. He complained of a pain and burning sensation in the right shoulder. Dr. Adams felt the patient's examination was consistent with impingement syndrome and the subacromial space was injected at that time. An MRI was recommended, as well. An MRI on 10/06/05 revealed supraspinatous tendonopathy, acromioclavicular degenerative joint disease, and subacromial/subdeltoid bursitis. On 10/19/05, Dr. Adams reviewed the MRI and recommended an arthroscopic subacromial decompression to include acromioplasty, a lateral clavicle resection, and a possible rotator cuff repair. On 10/28/05, Corvel denied the proposed right shoulder surgery, as the findings of the AC joint on the MRI were unusual and there was poor duration of the subacromial injection. Ms. Peizl provided a summary of the preauthorization history on 11/22/05 in response to the IRO request. On 11/28/05, Mr. Tipton from Flahive, Ogden, & Latson provided a summary of the carrier's position.

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Disputed Services:

Right shoulder arthroscopy, acromioplasty, lateral clavicle resection, and a possible rotator cuff repair

Decision:

I agree with the requestor. The right shoulder arthroscopy, acromioplasty, lateral clavicle resection, and a possible rotator cuff repair would be reasonable and necessary.

Rationale/Basis for Decision:

Yes, I believe it would be reasonable and necessary to perform the surgery. The patient had anatomic changes consistent with impingement syndrome in the right shoulder. The patient had been treated with exercise. He did have short term relief from an injection into the subacromial space. He had enough objective criteria for proceeding with shoulder surgery in this instance.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

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

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Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the patient via facsimile or U.S. Postal Service this day of 12/14/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel