


INDEPENDENT REVIEW INCORPORATED

December 14, 2006

REVISED December 15, 2006

Re: MDR #: M2 07 0284 01 Injured Employee: ___
DWC #: ___ DOI: ___
IRO Cert. #: 5340

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: Texas Mutual Insurance/Rick Ball

TREATING DOCTOR: Kathryn E. Schmidt, DO

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in orthopedic surgery and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to all participating parties and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

Your Right To Appeal

P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)

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.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on December 14, 2006.

Sincerely,

Jeff Cunningham, DC
Office Manager



**REVIEWER'S REPORT
M2 07 0284 01**

MEDICAL INFORMATION REVIEWED:

1. Notification of IRO assignment
2. Table of Disputed Services
3. Requestor's records
4. Nonauthorization letters from Texas Mutual Insurance Company
5. Notes from Trinity Orthopedics
6. Medical records from Larry M. Kjeldjaard, D.O.
7. Letters from Joseph Janser, D.O.
8. MRI report of the right shoulder dated 07/27/06
9. Trinity Rehabilitation notes
10. Multiple physical therapy notes from Gentiva Health Services
11. Carrier's records including physician statement from Texas Mutual Insurance Company dated 11/15/06
12. Emergency room records from the date of injury, Presbyterian Healthcare System, date of visit ____
13. Designated doctor examination dated 06/08/06
14. Letter from K.E. Schimdt, D.O. Dated 06/07/06
15. Operative report dated 10/17/05
16. Cervical epidural steroid injection note date 07/13/05
17. Initial consultation and EMG/nerve conduction study dated 02/27/06
18. Designated doctor evaluation dated 09/29/05
19. Pain management notes from Dr. Arguwald

BRIEF CLINICAL HISTORY:

The patient sustained multiple severe injuries after being hit by a steel beam on _____. He suffered a right femur fracture, nasal fracture, right scapula fracture, and cervical sprain. He was treated with intramedullary rodding of the right femur and underwent closed treatment of the right scapula fracture. In addition to chronic neck pain, he had chronic shoulder pain and was diagnosed with clinical evidence of impingement syndrome. He failed conservative management including therapy and steroid injections as well as oral medications, and arthroscopic treatment was requested.

DISPUTED SERVICES:

Right shoulder arthroscopy and acromioplasty have been denied as medically unnecessary by the insurance company.

DECISION:

I PARTIALLY AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:

In looking at the procedure that the physician is requesting, an extensive debridement is not indicated as there is no evidence of labral pathology on the MRI scan. An acromioplasty is medically necessary. Open rotator cuff repair, is not indicated for this patient as he has 5/5 strength with no evidence of rotator cuff pathology on clinical examination or on MRI scan. Finally, the unlisted procedure, is not approved as this unlisted procedure is not described anywhere in the requestor's notes. Therefore, I partially approve the acromioplasty. The other requested CPT codes are not indicated.

SCREENING CRITERIA/TREATMENT GUIDELINES/PUBLICATIONS UTILIZED:

Clinical experience, ACOEM Guidelines, and fellowship training in hand and upper extremity surgery has allowed me to make this clinical judgment. In addition, The Journal of Shoulder and Elbow Surgery as well as Orthopedic Textbook on the Shoulder have assisted in this decision.