

  
**INDEPENDENT REVIEW INCORPORATED**

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November 1, 2006

Re:    **MDR #:**        **M2 07 0070 01**        **Injured Employee:**    \_\_\_  
      **DWC #:**        \_\_\_                    **DOI:**                \_\_\_  
      **IRO Cert. #:** **5055**                **SS#:**                \_\_\_

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

**RESPONDENT:**                    **Texas Mutual Insurance**

**TREATING DOCTOR:**    **G. Peter Foon, MD**

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

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**Sulphur Springs, TX 75483**  
**903.488.2329 \* 903.642.0064 (fax)**

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 the payor 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

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 November 1, 2006.

Sincerely,

A stylized signature consisting of the lowercase letters 'j' and 'c' in a bold, serif font. The 'j' has a dot above it, and the 'c' is positioned to the right of the 'j'.

Jeff Cunningham, DC  
Office Manager

**REVIEWER'S REPORT  
M2 07 0070 01**

MEDICAL INFORMATION REVIEWED:

1. Notification of DWC assignment with insurance company denial letters
2. Carrier's records
3. Requestor's records

BRIEF CLINICAL HISTORY:

The patient is a 32-year-old male who suffered a work-related injury to his right shoulder. He had no previous history of shoulder injuries until the work-related accident. The patient has a chronic pain in his shoulder. He has failed extensive conservative management including physical therapy and steroid injections. Diagnostic arthroscopy and indicated procedures such as arthroscopic labral repair, rotator cuff repair, and acromioplasty were requested by Dr. McConnell. These were denied as medically unnecessary by the insurance company. The patient continues to have severe debilitating shoulder pain and limited range of motion. MRI scan and MR arthrogram did not show a cuff tear or labral tear. They did show supraspinatus tendinitis and impingement from the distal acromioclavicular joint and a type 2 acromion.

DISPUTED SERVICES:

Right shoulder arthroscopy with rotator cuff and labral repair has been denied as medically unnecessary by the insurance company.

DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:

The patient has a compensable injury to the right shoulder. He has chronic pain that has not responded to conservative measures for over 1 year. Occasionally MRI scan and even MR arthrogram fail to demonstrate surgical pathology, and a diagnostic arthroscopy and indicated procedures are indicated for this patient at this point. ODG Guidelines as well as The Shoulder Textbook by Drs. Madsen and Rockwood as the basis for this decision.