

NOTICE OF INDEPENDENT REVIEW DECISION

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October 24, 2006

Requestor

Respondent

TML c/o Flahive, Ogden & Latson  
ATTN: Katie Foster  
504 Lavaca, Ste 1000  
Austin, TX 78701

RE: Claim #: \_\_\_\_\_  
Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-07-0107-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Orthopedic Surgery, by the American Board of Orthopaedic Surgery, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1969, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and 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 IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient has complaints of right shoulder pain as a result of a work related injury on \_\_\_\_\_. The patient has undergone treatments including two prior surgeries, a pain clinic evaluation and a recommendation for repeat surgery.

Requested Service(s)

Right shoulder EUA arthroscopy with debridement SAD Mumford RCR with one day extension.

Decision

It is determined that the right shoulder EUA arthroscopy with debridement SAD Mumford RCR with one day extension is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient's current problem is chronic pain syndrome after two prior surgical procedures. There is insufficient documentation of the anatomic source of the pain to justify a surgical procedure indicated only by the relief of pain. Of all of the symptoms or signs that might be affected by surgery, pain is the least reliably relieved. Even when surgical procedures are successful in improving function, range of motion, and stability, pain frequently persists. Therefore, it is determined that there is insufficient documentation of objective findings to justify the performance of the surgical procedure.

This decision by the IRO 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.

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

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

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm  
Attachment

cc: Program Administrator, Medical Review Division, DWC

In accordance with Division Rule 102.4 (h), 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 this 24th day of October 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

**Patient Name:** \_\_\_\_

**Tracking #:** M2-07-0107-01

**Information Submitted by Requestor:**

- Table of disputed services
- Preauthorization history
- Reconsideration request
- Orthopaedic general clinic notes
- Report of MRI of the right shoulder

**Information Submitted by Respondent:**

- Letter from attorneys
- Table of disputed services
- Preauthorization history
- Reconsideration request
- Orthopaedic general clinic notes
- Report of MRI of the right shoulder