



## Medwork Independent Review

1217 Menomonie Street  
Eau Claire, Wisconsin 54703  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
medworkiro@charterinternet.com  
www.medwork.org



*NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION  
Workers' Compensation Health Care Non-network (WC)  
MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW:** 10/01/2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Continued physical therapy visits

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Texas State Licensed Board Certified Orthopaedic Surgeon

**REVIEW OUTCOME:** [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE.

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. Notice to Medwork of Wisconsin, Inc. DBA Medwork Independent Review of case assignment dated 09/21/2007
2. Notice to URA of assignment of IRO dated 09/21/2007
3. Confirmation of receipt of a request for a review by an IRO dated 09/20/2007
4. Company request for IRO section I-VIII
5. Request form – Request for a review by an IRO dated 09/20/2007 (patient request)
6. Preauthorization Determination dated 09/10/2007
7. Preauthorization Determination dated 07/05/2007
8. Physical therapy prescription dated 08/09/2007
9. Consult from MD dated 07/13/2007
10. Physical therapy prescription dated 06/28/2007
11. Progress notes dated 05/17/2007; 06/28/2007; 08/09/2007
12. EMG/NCV dated 04/30/2007
13. CT& MRI dated 04/18/2007



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14. Workers Compensation Info Form dated 04/05/2007

**PATIENT CLINICAL HISTORY:** [SUMMARY - REFRAIN FROM USING NAME]

This individual was involved in an accident. He sustained significant injury to his right forearm and hand.

He subsequently has been treated with physical therapy. He has had 27 sessions of physical therapy. He has recently been seen by Dr. Dr. indicates that there has been an unchanging pattern in his report and also indicates that there are some symptoms indicative of reflex sympathetic dystrophy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

I have used the ODG Guidelines in review. It is my opinion that based upon the 27 sessions of physical therapy; additional therapy would not be of value. It is my opinion that responsibility for therapy to include active exercise could be transferred to the patient's responsibility.



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### A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)