



## Medwork Independent Review

1217 Menomonie Street  
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1-800-426-1551 | 715-552-0746  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**Original decision date: 02/25/2008**

**Amendment date: 02/26/2008**

**DATE OF REVIEW: 02/25/2008**

**IRO CASE #:**

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

MRI of left shoulder

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

Texas State Licensed MD Board Certified Orthopaedic Surgeon

#### **REVIEW OUTCOME**

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. Texas Dept of Insurance Assignment to 02/05/2008
2. Notice to URA of assignment of IRO
3. Confirmation of Receipt of a Request for a Review by an IRO 02/04/2008
4. Company Request for IRO Sections 1-8
5. Request For a Review by an IRO patient request
6. Denial of Reconsideration of Preauthorization or Concurrent Review Request 02/04/2008
7. Denial of Reconsideration of Preauthorization or Concurrent Review Request/Physician Determination Appeal 01/31/2008
8. Denial of Reconsideration of Preauthorization or Concurrent Review Request 01/08/2008
9. Denial of Reconsideration of Preauthorization or Concurrent Review Request/Physician Determination Initial 01/04/2008
10. TDI Report of Medical Eval 01/24/2008; eval 01/24/2008
11. TDI Report of Medical Eval 01/16/2008; eval 01/16/2008



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12. Office visit 01/02/2008
13. TDI Workers' Compensation Work Status Report 01/16/2008
14. Fax cover sheet to UR dept 01/02/2008; MRI order 12/06/2007 & office note
15. Office note 11/09/2007; 10/17/2007 (along with prescription); 09/19/2007; 09/18/2007; 09/05/2007; 08/14/2007; 08/07/2007; 08/07/2007; 08/03/2007 & OP report
16. TDI Workers' Compensation Work Status Report 07/17/2007 & office note
17. Office note 07/10/2007; MRI 07/08/2007; 06/20/2007; 06/05/2007; 05/17/2007; 05/15/2007; 04/26/2007; 04/12/2007; 04/04/2007; 03/29/2007; 03/22/2007; MRI 02/15/2007
18. Discharge 01/10/2007
19. Xray 01/07/2007, OP report
20. Xray shoulder & knee 01/06/2007
21. CT , labs and H&P 01/06/2007
22. ODG guidelines were not provided by the URA

### **PATIENT CLINICAL HISTORY:**

This injured worker was involved in an accident on xx/xx/xx. At that time, he was employed as a xxxx. He sustained injury to his left shoulder and to his left knee. The knee required surgery to carry out an open reduction and internal fixation of a tibial plateau fracture. An MR scan was carried out of the left shoulder on February 15, 2007. This demonstrated full thickness tears of the supraspinatus and infraspinatus. Subsequently, further MR scan of the left shoulder was carried out on July 8, 2007. Again, this showed tendinosis with a full thickness tear of the supraspinatus tendon. On August 3, 2007, the patient underwent a repair of the rotator cuff to the left shoulder. He was treated postoperatively with physical therapy. This man was returned to work in January 2008. It was established he was reaching maximum medical improvement on January 24, 2008.

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

Using the guidelines of the American College of Occupational and Environmental Medicine Knowledge Base and the Official Disability Guidelines and Treatment Guidelines, it is my opinion that the decision for adverse determination should be upheld. There is no clinical reason for an MR scan to be repeated of this patient's left shoulder. He has had two previous MR scans following which surgery has been undertaken. MR scanning is a tool to be used as a treatment guideline.

### **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



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- 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)**