



## Medwork Independent Review

1217 Menomonee Street  
Eau Claire, Wisconsin 54703  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
medworkiro@charterinternet.com  
[www.medwork.org](http://www.medwork.org)



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

01/22/2008

**DATE OF REVIEW: 01/22/2008**

**IRO CASE #:**

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

Subacromial decompression and resection of distal clavicle, 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 Medwork 01/08/2008
2. Notice to URA of assignment of IRO dated 01/08/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 01/07/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/28/2007
6. Coventry Notice of Determination 01/07/2008
7. Coventry Review Summary 12/11/2007 & 12/04/2007
8. Utilization Review Referral not dated
9. History Sheet 01/03/2008; 11/26/2007; 10/12/2007
10. Summary of Care 10/10/2007
11. Physical Medicine & Rehab Outpatient Therapy order 10/01/2007
12. MRI 09/25/2007



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13. Texas Workers Compensation Work Status Report w/ Injury/Illness Record: 10/01/2007;  
09/25/2007; 09/18/2007; 09/12/2007; 09/10/2007; 09/05/2007

14. Fax cover sheets to Gallagher Bassett/Coventry 12/05/2007 & 11/27/2007

15. ODG guidelines were not provided by the URA

### **PATIENT CLINICAL HISTORY:**

Patient was involved in an accident. The patient subsequently has had complaints about the left shoulder. An MR scan was carried out on September 25, 2007. The interpretation showed bone contusion involving the distal aspect of the left clavicle and left acromion. I have reviewed the medical records indicating that the patient has a full range of motion. There has been no documentation of supervised physical therapy. There is no documentation of injection. There is no documentation of physical examination showing a painful arc syndrome, impingement, or any other objective criteria of acromioclavicular disease.

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

I agree and uphold the denial for a subacromial decompression and resection of distal clavicle left shoulder. This is based on medical judgment and ODG Guidelines. I would recommend that this patient have further nonoperative treatment.

### **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 KNOWLEDGBASE
- 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



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- 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)**