



Medwork Independent Review

1217 Menomonie Street
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)

03/12/2008

DATE OF REVIEW: 03/12/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Removal deep hardware, left wrist fusion

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:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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 02/25/2008
2. Confirmation of Receipt of a Request for a Review by an IRO 02/22/2008
3. Company Request for IRO Sections 1-8 undated
4. Request For a Review by an IRO patient request 02/21/2007
5. letter 1st Appeal 01/22/2008
6. letter First Review 01/14/2008
7. GAO Pre-Cert Fax 01/09/2008
8. GAO Pre-Cert Appeal Fax 01/16/2008
9. GAO letter Dr. 01/16/2008
10. Office Note 01/07/2008; 12/10/2007; 11/27/2007; 11/13/2007 GAO patient info form, 11/13/2007; 11/12/2007 GAO Worker's Comp Form
11. ODG guidelines not provided by the URA

PATIENT CLINICAL HISTORY:



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This is an individual who was involved in an accident. He sustained a left distal radius fracture. Subsequently, he was seen by a doctor on November 13, 2007. Surgery was recommended. On November 15, 2007, the patient underwent open reduction and internal fixation. Back in the office, it was noted that his fixation was intact. He was put into a spica. Staples were removed. He subsequently was seen in January of 2008. At that time, there was noted to be some loosening of his hardware. At that time, his physician recommended that he consider a fusion. There had been no other type of treatment undertaken. There had been no further type of surgery described or offered.

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

In summary therefore, this is a man who sustained a left distal radius fracture. He has undergone surgery. He has had some subluxation of the radiocarpal joint dorsally. There is some displacement of his radial styloid fracture. A wrist fusion has been offered.

In my opinion, the previous adverse determination should be upheld.

Using the ODG Guidelines, this man does not fulfill the criteria for a wrist fusion.

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



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- 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)**