



Medwork Independent Review

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

10/01/2008

DATE OF REVIEW: 10/01/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional Physical Therapy

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 09/15/2008
2. Texas Dept of Insurance notice to URA of assignment of IRO 09/15/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 09/12/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 09/11/2008
6. adverse determination letter reconsideration 08/29/2008
7. adverse determination letter, initial review 08/22/2008
8. fax cover dated 09/02/2008
9. preauthorization request form (3rd request for reconsideration)
10. Orthopedic Surgery Group therapy referral/hand therapy center 08/29/2008
11. preauthorization request form (2nd request for reconsideration)
12. Orthopedic Surgery Group therapy referral/hand therapy center 08/08/2008
13. preauthorization request form (initial request for reconsideration)
14. Orthopedic Surgery Group MRI 08/22/2008
15. Orthopedic Surgery Group office note 08/08/2008 & 07/28/2008
16. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY:

This is a patient that has been treated for shoulder pain. Office note for July 28, 2008 was documented that the patient had not had any significant reduction in his neck and left shoulder symptoms despite physical therapy. In clinical note which is dated August 8, 2008, specifically, it indicates, "This patient has not responded to conservative treatment up to this point." He also indicates that, "Despite therapy so far has not helped, we do want him to continue that for at least a couple of months." This patient has had an MRI scan of the left shoulder. It was undertaken on August 22, 2008 showing a subacromial spur with tendinitis.

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

This patient has failed to respond to physical therapy. Continued physical therapy would not be in agreement with ODG Guidelines. The previous adverse determination should be upheld. There is no logical reason for continuing a modality treatment that has not proven effective thus far.

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)