



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 11/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopy w RCR, acromioplasty, bicep renodesis, suprascapular nerve block and surgical assistant

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 11/10/2009
2. Notice of assignment to URA 11/10/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 11/09/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 11/09/2009
6. letter 11/06/2009, 10/23/2009
7. Appeal rqst 11/05/2009, fax rqst 10/20/2009, scheduling sheet 10/14/2009, pt info sheet, medical note 10/14/2009, 05/08/2009, 03/27/2009, 12/01/2008, 11/24/2008, 11/12/2008, MRI 10/14/2008
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This individual was involved in an accident xx/xx/xx and subsequently has had pain in the right shoulder. An MRI scan was carried out on October 14, 2008. This has shown a tear of the supraspinatus. It has shown a tear of the infraspinatus with retraction and some atrophy. There are degenerative changes in the acromioclavicular joint. Medical records state that the patient has had "a little bit of therapy, mostly a home exercise program, but no injections."

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



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



The patient does not currently fulfill Official Disability Guidelines' criteria for the requested procedure. There is inadequate documentation of appropriate non-operative care. The adverse determination is upheld.

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
- 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)