



Medwork Independent Review

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

12/21/2009

DATE OF REVIEW: 12/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Scope right shoulder & carpal tunnel release (29822, 29826, & 64721)

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 & Spine 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 12/1/2009
2. Confirmation of Receipt of a Request for a Review by an IRO 12/1/2009
3. Company Request for IRO Sections 1-8 undated
4. Request For a Review by an IRO patient request 11/24/2009
5. letter 11/19/2009, 10/16/2009
6. Office Notes 9/24/2009, 2/12/2009, , 11/20/2008, 10/22/2008, , 7/3/2008, 5/22/2008, 11/13/2007, 6/25/2007, 5/3/2007, 3/21/2006, neurodiagnostic study 12/2/2008, nerve conduction study 12/2/2008, shoulder x-ray 11/20/2008, 11/13/2007, MRI 3/21/2006, 12/20/2005, 7/6/2005, operative report 1/24/2009
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

This patient has had previous right shoulder arthroscopy. X-rays done in November 2008 did not show any significant pathology. In December 2008, there were nerve conduction studies showing some slowing of the median nerve. There is no documentation of any positive findings suggesting carpal tunnel syndrome. EMGs themselves were normal. Request is for scope right shoulder & carpal tunnel release.



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

Using Official Disability Guidelines, there is insufficient documentation of information to suggest that this patient is a candidate for shoulder arthroscopy or carpal tunnel surgery. The records reviewed do not support the medical necessity of the request. The previous 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)