



Medwork Independent Review

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

MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 07/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Shoulder Arthroscopy CPT 29805

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 07/13/2009
2. Confirmation of Receipt of a Request for a Review by an IRO
3. Company Request for IRO Sections 1-8 undated
4. Request For a Review by an IRO patient request 07/08/2009
5. determination letter 07/02/2009 & 06/19/2009, 03/16/2009
6. notice of disputed issues and refusal to pay benefits 04/30/2009, 03/11/2009
7. UR referral 07/07/2009, 06/22/2009 & 06/16/2009
8. Medical note 06/16/2009, 05/12/2009, 05/01/2009, 04/15/2009, 04/14/2009, 04/07/2009, 03/31/2009, 03/11/2009, 02/20/2009
9. Texas workers' compensation work status reports 06/16/2009, 05/12/2009, 04/15/2009
10. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This patient sustained an injury to the left upper extremity on xx/xx/xx. The patient was sent for therapy. The therapy could not be tolerated by the patient because of wrist pain. The patient is recovering from wrist surgery. The patient has been noted to have a scapholunate injury, for which surgery has been undertaken. The physician has indicated in that note that the mild



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acromioclavicular joint arthritis was probably not causing him a problem. A MRI scan notes mild acromioclavicular joint degenerative changes with no acute abnormality of the glenohumeral joint. There is no evidence of any rotator cuff tear or abnormal fluid accumulation.

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

The patient does not fulfill *Official Disability Guidelines'* criteria for subacromial decompression or arthroscopy of the shoulder. The patient has not been through adequate non-operative treatment, including physical therapy. The previous adverse determination should be 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 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)