



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



DATE OF REVIEW: 07/14/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroscopy with rotator cuff repair, acromioplasty, nerve block and pain pump

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 06/24/2009
2. Notice of assignment to URA 06/24/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 06/22/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 06/19/2009
6. adverse determination letter 06/01/2009 , 05/07/2009
7. Medical note 05/18/2009, 04/27/2009, 04/27/2009 & 04/04/2009 auth paperwork, 03/30/2009, MRI 03/11/2009 & 03/03/2009, letter from MD not dated
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient had injury to shoulder xx-xx-xx. The initial report dated March 30, 2009 the assessment at that time was right shoulder subacromial bursitis and a right deltoid contusion. Patient had an MRI scan, which the doctor had reviewed. The physician specifically did not note any evidence of a full-thickness cuff tear. The biceps was in appropriate position. The subscapularis was intact. At that time it was the physician's opinion that "I do not see anything there that I can do surgically for him." In the follow-up records it has been recommended that he have surgery. He has had no intervening imaging study. There are no additional findings.

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



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Based on the Official Disability Guidelines there is insufficient medical documentation to support the requested services. The MRI scan has not shown a demonstrable lesion requiring the procedure and there has been no change in the patient's evaluation. The previous adverse determination should be upheld. The records do not support the medical necessity of the request.

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)