



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 10/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopy, shoulder surgery with rotator cuff repair

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 10/12/2009
2. Notice of assignment to URA 10/12/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 10/09/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 09/09/2009
6. letter 10/08/2009, medical review 10/07/2009, letter 08/20/2009, medical review 08/20/2009, medical note 07/06/2009, radiology reports (3) 06/23/2009, pre-auth reqst 06/08/2009, radiology report 10/16/2008, CT 06/04/2008 & 05/20/2008
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Claimant was involved in an accident in xx/xxxx. His assessment has shown chronic glenohumeral arthritis with cyst formation. He has a chronic acromioclavicular joint separation. There has been atrophy of the supraspinatus and infraspinatus. The claimant has been treated with pain medications and shoulder injections. The records reviewed show no documentation of conservative care consisting of medications, physical therapy or exercises. The request was for a rotator cuff repair.

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



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Upon review of Official Disability Guidelines and the imaging studies, it would appear that this patient would not benefit from the requested procedure. The previous adverse determination should be upheld. The requested procedure is not recommended for the claimant's condition. The records reviewed do not show documentation of conservative treatments/care including medications, physical therapy or exercises as recommended per the ODG guidelines.

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)