



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)*

01/27/2010

#### *MEDWORK INDEPENDENT REVIEW DECISION (WCN)*

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**DATE OF REVIEW: 01/27/2010**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Rt shoulder arthroscopy: distal clavicle excision, SAD & CAL release, w rt shoulder brachial plexus cont infusion & rt elbow cubital tunnel release

**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 01/13/2010
2. Notice of assignment to URA 01/13/2010
3. Confirmation of Receipt of a Request for a Review by an IRO
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/30/2009
6. letter 12/11/2009, 12/04/2009, 11/20/2009
7. Office of Injured Employee Counsel letter 01/07/2010
8. Medical note 12/14/2009, referral 12/08/2009, medical note 12/07/2009, pre-auth rqst 11/17/2009, surgery scheduling form 11/04/2009, medical note 11/04/2009, 10/07/2009, UR referral rqst 09/08/2009, medical note 09/04/2009, prescription 08/18/2009, progress note 08/18/2009, radiology reports shoulder & elbow 07/30/2009, FCE 02/09/2009, medical note 11/21/2008, 11/12/2008, EMG/NCS 11/12/2008, medical note 10/24/2008, TDI form 12/07/2009 & 10/07/2009
9. ODG guidelines were not provided by the URA



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### **PATIENT CLINICAL HISTORY:**

The patient was involved in an accident on xx/xx/xx. The patient underwent EMG studies on November 12, 2008. These EMGs were normal with nerve conduction studies carried out in the right upper extremity as also being normal. There was no evidence of any ulnar nerve dysfunction. The records dated November 21, 2008, the ulnar nerve performed well on the test. There was no current expectation of this case needing any surgery. MRI scans were carried out on July 30, 2009. The MRI scan of the right elbow showed a small joint effusion. It indicates that the major tendon attachments were maintained. The regional musculature and subcutaneous tissues appeared intact. The anterior band of the medial ulnar and collateral ligament appeared maintained. The MRI scan of the right shoulder dated July 30, 2009, there was a type 2 acromion. There was some capsular hypertrophy and degenerative change at the acromioclavicular joint. There was minimal distal rotator cuff tendinopathy. The December 14, 2009 exam of the shoulder showed normal range of motion.

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

Based on the Official Disability Guidelines, the previous adverse determination is upheld. The documentation reviewed does not support the medical necessity of the requested. Using the Official Disability Guidelines, this patient does not fulfill the criteria for the requested right shoulder arthroscopy, distal clavicle excision, SAD and CAL release with right shoulder brachial plexus continual infusion and right elbow cubital tunnel release.

### **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



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- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**