



Medwork Independent Review

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

03/22/2010

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 03/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

29805 left shoulder arthroscopy with open 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 03/02/2010
2. Notice of assignment to URA 03/02/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 03/01/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 02/26/2010
6. letter 02/05/2010, 01/19/2010, IRO review rqst not dated, claims management notice 11/17/2009
7. Pre-auth 01/29/2010 & 01/14/2010, physical performance eval 01/12/2010, referral form & history & progress note 01/11/2010, functional abilities eval 12/14/2009, medical note 12/07/2009, eval 11/23/2009, 11/13/2009, medical note 11/10/2009, 10/30/2009, MRI 10/28/2009, medical note 10/20/2009, 10/16/2009, 10/15/2009, 10/13/2009, 10/06/2009, 10/05/2009, 09/30/2009, 09/29/2009, radiology report 09/18/2009, medical note 09/18/2009
8. TDI forms 11/12/2009, 11/01/2009, 10/20/2009, 10/08/2009, 10/02/2009, 09/16/2009, first injury report xx/xx/xxODG guidelines were not provided by the URA,



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PATIENT CLINICAL HISTORY:

The patient was involved in work that required repetitive lifting and pushing. She developed left shoulder pain. This got acutely worse on August 15, 2009. She was given physical therapy. She subsequently has had an MRI scan. MRI dated October 28, 2009, there is a complete rotator cuff tear within the distal supraspinatus tendon at its insertion. There is no evidence of tendon retraction or muscle atrophy. This would reflect the relatively acute or subacute nature of this injury. The request is for left shoulder arthroscopy with open rotator cuff repair.

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

This patient fulfills the Official Disability Guidelines' criteria for operative treatment. The previous adverse determination is overturned based on the criteria of the ODG guidelines. This patient has shown to have symptoms and findings in keeping with a symptomatic rotator cuff tear. This patient would benefit from the requested left shoulder arthroscopy with open rotator cuff repair.

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)