



## 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



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

04/27/2010

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 04/27/2010**

**IRO CASE #:**

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

Right elbow arthroscopy with lateral release

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Texas State Licensed MD Board Certified Orthopedic 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 xxxx 04/08/2010
2. Notice of assignment to URA 04/08/2010
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 04/05/2010
6. xxxxx letter 03/22/2010, 02/15/2010
7. Medical note 03/05/2010, 02/05/2010, 02/01/2010, 01/04/2010, 12/21/2009, 12/14/2009, 10/28/2009, 10/21/2009, 09/30/2009, 09/24/2009, 09/23/2009, 09/15/2009, 09/10/2009, 09/15/2009, radiology 09/10/2009, pt referrals,
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This patient was involved in an accident on xxxxx. The patient has subsequently had right elbow pain. This patient has been treated with a steroid injection, bracing, and anti-inflammatories. Request is for right elbow arthroscopy with lateral release.



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

Review of the records indicates that the patient has failed non-operative treatment, including 2-injection therapy in 5 months with splinting on and off, as well as anti-inflammatories and activity modification. The claimant fulfills the criteria in the Official Disability Guidelines for the requested right elbow arthroscopy with lateral release; therefore the previous determination is overturned.

### **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)