



## Medwork Independent Review

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

**01/26/2011**

**DATE OF REVIEW: 01/26/2011**

**IRO CASE #:**

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

Right shoulder decompression (23120, 23130, & 20926)

**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 Medwork 01/10/2011
2. Notice of assignment to URA 01/10/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 01/07/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 01/06/2011
6. Insurance letter 01/11/2011, 01/04/2011, 12/07/2010, Follow up 12/01/2010-10/27/2010, Medicals 12/22/2010, 12/09/2010, 11/23/2010, 10/20/2010, 09/27/2010, 04/21/2010, 02/24/2010, 04/21/2008, ODG Guidelines.
7. ODG guidelines were provided by the URA

**PATIENT CLINICAL HISTORY:**

This claimant was involved in an accident on xx/xx/xx. The patient subsequently has had complaints of right shoulder pain. An MRI scan was carried out; this MRI scan was reported as normal. Because of ongoing complaints and failure to respond to nonoperative management, the patient underwent a further MRI scan on February 24, 2010. This showed tendinosis, a labral cyst, and some arthritic changes in the acromioclavicular joint. On April 2, 2010, the patient underwent a right shoulder procedure. This procedure included arthroscopic subchondral decompression, biceps tenodesis, and distal clavicle excision. Postoperatively, the patient has



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continued to have pain. The patient has had physical therapy. An injection into the shoulder was undertaken on November 10, 2010. There have been no postoperative imaging studies. Patient continues to have pain. The physician has requested a right shoulder decompression (23120, 23130, & 20926).

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

The requested right shoulder decompression (23120, 23130, & 20926) falls outside of Official Disability Guidelines. There is insufficient data to recommend any further intervention for this patient. There has not been any postoperative imaging assessment. There is inadequate documentation of underlying pathology requiring surgical intervention. In review of the records presented and the ODG recommendations, the insurer's denial of the requested right shoulder decompression (23120, 23130, & 20926) is upheld.

### **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)