



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 9/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Open left shoulder rotator cuff repair and use of tendon graft.

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. Assignment 8/30/2011,
2. Notice of assignment to URA 08/29/2011,
3. Confirmation of Receipt of a Request for a Review by an IRO 08/29/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 08/29/2011
6. Insurance 08/25/2011, 08/12/2011, Medicals 08/02/2011, 07/28/2011, 07/14/2011, 07/13/2011, Insurance 07/05/2011, Medicals 06/28/2011, 06/20/2011, 05/17/2011, Post Procedure 05/12/2011, Operative Report 06/28/2011, 6/20/2011, 5/17/2011, 5/12/2011 Insurance 05/09/2011, 05/05/2011, Medicals 05/03/2011, 04/28/2011, 03/15/2011, 03/11/2011, 03/01/2011, 01/28/2011, 01/18/2011, 12/22/2010, 11/16/2010, 07/23/2010, 07/19/2010, 07/15/2010, 07/01/2010, 06/21/2010, 06/09/2010, 05/20/2010, 05/10/2010, 04/16/2010, 03/16/2010, 03/10/2010, 03/03/2010, 02/17/2010, 01/06/2010, 02/23/2009.

PATIENT CLINICAL HISTORY

This patient's original injury was on xx/xx/xxxx. He underwent surgery to repair a rotator cuff tear on March 10, 2010. Unfortunately, recurrence occurred, and revision scope and repair was carried out on May 11, 2011. Since that time, the patient has had another episode in which there was a sudden onset of pain and swelling. Subsequently, an MR arthrogram has showed recurrence of retraction of the subscapularis tendon, indicating a failure of surgery.



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The attending physician now wishes to carry out an open left shoulder rotator cuff repair and use of a tendon graft.

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

Official Disability Guidelines indicate that often times, open repair is more successful than arthroscopic repair. Certainly, in a patient who has had failed surgery, an open repair would be preferable. For that reason, the request for an open rotator cuff repair is allowed. The attending physician has also requested the use of a tendon graft. Although Official Disability Guidelines indicate that the use of tendon grafts are under study, it is commonplace to use these grafts, particularly in patients who have large tears in which the ends cannot be re-approximated or in cases such as this in which there has been recurrence of a tear because of failure of the anchor. The request for an open rotator cuff repair and tendon graft falls within the standards of care and generally accepted guidelines for medical treatment of this condition; therefore, the insurer's decision to deny 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 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
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)