



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)

January 25, 2012

DATE OF REVIEW: 1/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is Arthroscopic surgery, right shoulder, with decompression deemed medically necessary for this patient?

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 & Spine Surgeon

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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 1/05/2012,
2. Notice of assignment to URA 1/04/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 1/05/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 1/05/2012
6. Insurance 12/29/2011, letter from surgeon associates 12/14/2011, prescription write up 11/29/2011, medical documentation 11/29/2011, letter from insurance 11/21/2011, preauthorization request 11/16/2011, letter from surgeon associates 11/15/2011, prescription write up 10/31/2011, medical documentation 10/31/2011, 10/13/2011, 10/04/2011, 9/27/2011, 9/26/2011, medical information 9/8/2011.
7. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY:

The patient was documented to have been considered for arthroscopic surgery, right shoulder, with decompression.

The most recent record was dated December 15, 2011. On that date, persistent right shoulder pain with AC joint tenderness and positive Hawkins sign was noted. Results of an MRI from September 28, 2011, have been noted to reveal tendinosis of the rotator cuff with subacromial bursitis and a degenerative cyst in the greater trochanter. The patient has been noted by the treating provider to reportedly have failed prior cortisone injections at the level of the affected shoulder, along with medications and therapy, and therefore the Attending Physician felt that the patient has indication for surgical intervention.

Documents have been provided for the date of November 15, 2011, from the treating provider, in addition to prior pain management notes from Dr.. The patient previously had been noted on September 8, 2011, to have evidence of a box having fallen. "She tried to hold on with her right arm to prevent a fall and she hurt her right shoulder." The impingement sign was negative on that date. Additional records from the treating provider discussed evidence of "symptom magnification" as of November 29, 2011. The "gentle passive range of motion increases the symptoms significantly."

It was noted the prior records from the same provider were also reviewed, with the diagnosis of impingement syndrome, right shoulder. The MRI report was as noted above and dated September 28, 2011, and was also reviewed.

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

After review of the records provided, this patient does not fulfill Official Disability Guideline's criteria for the arthroscopic surgery, right shoulder, with decompression; therefore the insurer's decision to deny the requested is upheld. The records reviewed are not adequate in support of the recommendations of the ODG guidelines.

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



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- 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)**