



Medwork Independent Review

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

DATE OF REVIEW: 6/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy with subacromial decompression, extensive debridement, possible synovectomy, possible repair rotator cuff tendon and possible excision of distal clavicle end.

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 6/11/2012,
2. Notice of assignment to URA 5/31/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 6/11/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 6/8/2012
6. Non-certification letter 6/1/2012, letter from orthopedic group 6/1/2012, non-certification letter 5/30/2012, work status report 5/16/2012, medical information 5/16/2012, 4/18/2012, 3/7/2012, 2/9/2012, 1/12/2012, 12/13/2011, 12/1/2011, 11/3/2011, 10/20/2011, 9/15/2011, 8/23/2011, 8/3/2011, letter from orthopedic group 5/26/2011, medical information 4/28/2011, letter from orthopedic group 4/18/2011, medical information 3/31/2011, 3/22/2011, letter from orthopedic group 3/8/2011, medical information 2/8/2011, letter from orthopedic group 1/25/2011, medical information 1/11/2011, letter from orthopedic group 1/11/2011, information from imaging group 12/21/2010, new patient evaluation 12/9/2010, letter from orthopedic group 12/9/2010.

PATIENT CLINICAL HISTORY:



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The patient has been noted, in a summary letter of appeal dated June 1, 2012, to have been considered for left shoulder surgical intervention. It was noted by the treating provider that there had not been any "reasonable justification for the denial." It was noted that the denial letter had indicated that there was a lack of correlation between the clinical findings and the MRI.

The treating provider indicated that the medical records "clearly provide correlation between the patient's diagnosis, the MRI findings, and the proposed surgical procedures." The fall at work on the DOI of November 12, 2010, was noted. The overall diagnoses had included that of left shoulder cuff injury, possible cuff tear, along with AC arthritis and bicipital tendinitis. An MRI from December 21, 2010, reportedly was suboptimal due to body habitus and motion. The scan, however, reportedly revealed supraspinatus tendinitis and trace fluid in the bursa. Negative for rotator cuff and/or labral tear and/or biceps tear. Non-operative treatment was noted to have occurred "without benefit." The patient reportedly had been considered for surgical intervention by another provider, and it was then noted that the patient/AP's patient had "started to see me for evaluation and treatment of her left shoulder..." Multiple cortisone injections were noted to have provided short-term relief, and most of the pain was localized to the cuff and to a lesser extent the AC joint. The proposed surgical procedures were delineated in detail and were felt to correlate "with the patient's history, examination, diagnosis, and MRI findings," per Dr. de Young.

The records from the physician were noted to include, from May 16, 2012, the diagnoses at the shoulder level to include "left shoulder strain/sprain with posttraumatic rotator cuff tendinitis and AC osteoarthritis probably aggravated by the work injury."

The prior records were also reviewed in detail. The recurrent pain and abnormal clinical findings of the affected shoulder were reviewed, including a painful arc of motion at the left shoulder, along with prior treatments.

The records from throughout 2012 were reviewed in detail. The treatment records, including the injection notes, were also specifically reviewed and were also inclusive of the records from 2011, which were reviewed at this time, also.

The records from another physician were also reviewed, including from December 9, 2010, with the diagnosis of left rotator cuff injury, rule out tear; bicipital tendinosis; and AC arthritis, among others.

The MRI of shoulder, left, dated December 21, 2010, revealed tendinosis and fluid in the subacromial bursa.

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



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The patient clearly, as has been most recently stated by the treating provider, has had months of treatment of the affected shoulder without benefit that has been at all longstanding or adequate. The failure of treatments, including restricted activities, medications, and injections, has been well documented and clearly correlate with the clinical indications for the proposed surgical interventions.

The MRI findings do not at all preclude the proposed surgery, as it is well documented in orthopedics, based on the overall intent of the Official Disability Guidelines with regard to impingement syndrome and, for that matter, rotator cuff repair, that clearly a persistent clinical issue with both subjective and objective findings over months has an indication for the proposed procedures. The entirety of the procedures, including left shoulder arthroscopic surgery, subacromial decompression, debridement, possible synovectomy, cuff repair, and possible distal clavicle excision, is reasonable and necessary as per the Official Disability Guidelines for surgical treatment of impingement syndrome and cuff repair if applicable, and the procedure should be certified at this time; therefore, the insurer's denial 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)