



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC*

Date: November 2, 2012

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW:** 11/2/2012

**IRO CASE #:**

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

Physical therapy 2 times a week for 6 weeks for the right shoulder.

**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**

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 10/15/2012,
2. Notice of assignment to URA 10/12/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 10/15/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/15/2012
6. Letter to IRO from patient 10/25/2012, letter to patient from insurance company 10/16/2012, medical documents 10/4/2012, 9/26/2012, 9/21/2012, letter to patient from insurance company 9/17/2012, letter to therapy facility from insurance company 8/29/2012, medical documents 8/22/2012, 8/20/2012, 8/16/2012, 8/15/2012, 8/14/2012, 8/13/2012, 8/10/2012, 8/9/2012, 8/8/2012, 8/7/2012, 8/3/2012,8/2/2012, 8/1/2012, letter from massage therapist 7/31/2012, ODG treatment guidelines.

**PATIENT CLINICAL HISTORY:**



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The patient is a male who is a diabetic with a history of an injury that was sustained while working and lifting heavy die objects. He has been treated for an impingement syndrome and has documented on 03/14/2012 to have a positive MRI for at least a partial rotator cuff condition with impingement syndrome. He has been treated with 12 therapy sessions and reportedly has had no additional therapy except for some prescribed self administered therapy of which he has done on a less frequent basis, per the reports from the treating provider's office. Reports most recently from September 2012, specifically 09/21/2012, have revealed at the treating provider's office that the patient's right shoulder abduction was only 40 degrees. However, the day before on 09/20/2012, there was active abduction of the shoulder of 180 degrees.

The patient has reported in a letter of appeal that he has overall lost motion over time and that he has persistent right shoulder pain. The denial letters have also been reviewed.

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

This patient has had persistent shoulder pain that most recently has been diagnosed by the treating provider has being reasonable compatible with a tendency towards adhesive capsulitis. There is a significant rather inexplicable discrepancy between the therapist report on 09/20 and the provider's report on 09/21 with regard to degrees of abduction and also other measures of shoulder motion at the patient's right shoulder. However, being a diabetic and having an evident impingement syndrome and/or partial cuff tear, does predispose this individual towards a case of adhesive capsulitis. ODG guideline supports 16 visits specifically for treatment of adhesive capsulitis. At this time, in light of the discrepancy of the most recently documented range of motion and in light of the fact that the treating provider has requested 12 visits of therapy for the right shoulder, the intent of the applicable ODG guidelines has been met. It is most likely that post this course of therapy specifically for this diagnosis, that the patient will likely have a significantly overall improved outcome and likely ability to maintain such an outcome with a future likely prescribed and self-administered protocol. At this time, however, ODG guidelines have been met with regard to a diagnosis of adhesive capsulitis and the request is reasonable, medically necessary, and should be certified based on applicable ODG criteria.

The denial of services 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



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- 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)**