



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: August 13, 2013

DATE OF REVIEW: 8/13/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twelve sessions of physical therapy 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 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 7/25/2013,
2. Notice of assignment to URA 7/11/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 7/23/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 7/23/2013
Adverse determination letter 7/1/2013, preauthorization request form, therapy referral, 6/3/2013, evaluation notes 6/3/2013, adverse determination letter 5/16/2013, preauthorization request form re-evaluation notes 5/13/2013, PT daily progress notes 5/10/2013, 5/9/2013, 5/7/2013, therapy referral 5/6/2013, evaluation 4/1/2013, MRI report 3/14/2013

PATIENT CLINICAL HISTORY:

The claimant has been noted to have had a history of a labral tear of the right shoulder sustained while working. He had been working until the injury on xx/xx/xx. The claimant was noted to have sustained a strain of the shoulder. The claimant was noted to have full range of motion with 5/5 strength essentially, with positive Neer and Hawkins sign. MRI from 03/14/2013



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revealed tendinopathy only. The most recent records described a prescription for additional therapy. On 06/03/2013 it was noted that restrictions were to continue, that being "light duty, but there is no light duty for him." The records from 06/03/2013 discussed that the injury mechanism occurred when carrying a 100 pound device. It was noted that "he has a previous surgery for a labral tear and he was doing well until he had this strain of his shoulder." The claimant was noted to have strength 5-/5 with a persistent Neer and Hawkins impingement with full range of motion.

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

The most recent records do not evidence any residual or recurrent issues related to motion or strength that could not plausibly be addressed exclusively by a prescribed and self-administered therapy program. This is as per the applicable ODG guideline criteria regarding physical therapy for the shoulder. Therefore, the prior denial or denials with regard to additional therapy are 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 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)