



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 12/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder lysis of adhesions, distal clavicle resection, decompression.

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. Dept of Insurance Assignment to Medwork 12/2/2013
2. Notice of assignment to URA 11/27/2013
3. Confirmation of Receipt of a Request for a Review by an IRO 12/2/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/27/2013
Preauthorization request for surgery 11/20/2013, request for reconsideration of adverse determination from insurance plan 10/25/2013, request for authorization 9/24/2013, physician work activity status report 9/6/2013, patient referral 9/6/2013, medical notes 7/24/2013, physician findings 6/22/2013, patient referral 6/22/2013, transcription 6/22/2013.

PATIENT CLINICAL HISTORY:

The patient has been well documented to have been injured while working back in xx/xxxx. The patient was specifically noted on xx/xx/xx, to have sustained a right shoulder injury. The injury mechanism was not evident at this time. It was noted, however, that he has been treated with a cortisone injection, which only decreased pain significantly for several days. He has also been treated with medications and a course of therapy to the right shoulder. He has continued to report pain, including issues with reaching and overhead activities and also nocturnal pain,



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including "sleeping on his shoulder at night" as noted on multiple dates, including on September 6, 2013.

The MRI from July 24, 2013, has revealed at least two tears, including a "near insertional" articular partial tear and an "insertional articular tear." The "moderately severe traction spurring" has also been noted, as has reactive edema at the AC joint. The most recent exam findings have documented positive tenderness at the AC joint, along with "pain with abduction and internal rotation. Positive Hawkins sign. Weakness of the rotator cuff tendon, more so than before." This was noted on October 25, 2013.

The patient's letters of denial have referenced the lack of specific therapy at the level of the shoulder and the lack of 3-6 months of conservative treatment. The appeal letter has discussed the persistent subjective and objective findings, including the nocturnal pain and the imaging studies.

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

Per the documents provided, the patient has had quite adequate treatments in the form of medication, injection, and therapy and restricted activities. The patient clearly has both the subjective and objective findings that correlate with the Official Disability Guidelines parameters. The patient has a contributing factor noted on MRI that would tend to create recurrent impingement that is the significant spurring. The patient has had a reasonable trial of non operative treatment documented over a period of at least several months and therefore the Official Disability Guidelines' criteria has been met in full with regard to the request, especially for treatment of the most recently documented severe motion deficit of 100 degrees of abduction and 100 degrees of forward flexion, as documented on September 6, 2013. The patient clearly has residual adhesions and impingement affecting activities of daily living and has failed reasonable non operative treatment.

The denial of the services is overturned.



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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)