



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 5/20/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopic including subacromial decompression for impingement syndrome.

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

PATIENT CLINICAL HISTORY:

The claimant was most recently documented to be evaluated in the provider's office as of xxxxx. There was a history of bilateral shoulder pain and limited function in the female. The mechanism of injury was reportedly attributable to "repetitive use due to work duties." Prior treatments were noted to have included activity modification, NSAIDs, "bilateral shoulder subacromial steroid injections," and therapy for a greater than 6-month period. There was persistent bilateral shoulder pain, especially with reaching. The MRI bilaterally had shown "evidence for bilateral subacromial impingement." The provider documented the positive painful shoulder at about 90 degrees with positive impingement. The impression was sprain, rotator cuff syndrome and it was felt by the treating provider that there was an indication for "left shoulder arthroscopy with subacromial decompression and debridement." The prior records from the same provider, were reviewed documenting the prior treatments as referred to above, in particular regarding medications and injection of the left shoulder including the prior 04/15/2014. The denial letter dated 04/11/2014 discussed that it was to the reviewer "confusing as to exactly what treatment has been given to the left shoulder since the injury..."



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

The claimant clearly has had a combination of subjective and objective findings compatible with the imaging evidencing impingement. The claimant clearly has had a trial and failure of reasonable amount of treatments involving the left shoulder. Therefore, the applicable ODG criteria have been met for the request and it should be considered at this time medically reasonable and necessary.

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)