



Medwork Independent Review

2777 Irving Blvd, Ste 208
Dallas, TX 75207-2309
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 01/21/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left shoulder arthroscopic debridement.

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.

PATIENT CLINICAL HISTORY:

The XX-year-old was noted to have been injured in XX/XXXX. The injury mechanism was associated with having been lifting a piece of pipe. There was a history of the co-worker having reportedly dropped his portion of the pipe, resulting in the claimant's shoulder experiencing acute pain. The clinical records submitted for review include documentation from XX/XX/XX. It was noted that he was XX-year-old, who had felt a painful pop and had experienced subsequent bruising and persistent pain. He was noted to typically engage in a "high-demand profession." The individual was noted to be "unable to abduct or forward flex his arm secondary to pain." The MRI report from XX/XX/XX revealed a biceps tendon tear with retraction to the humeral neck level. There was also a small focal tear of the supraspinatus and degenerative changes of the AC joint. The treating provider had indicated that surgery was applicable. Prior records from XX/XX/XX discussed that treatment included medications and the use of a sling. Denials had noted the lack of comprehensive shoulder, evaluation, exam and/or documentation of same and the lack of indication of underlying symptoms from the distal clavicle. The denials further indicated the lack of indication for the requested tenodesis to be performed in the relative acute setting.



Medwork Independent Review

2777 Irving Blvd, Ste 208

Dallas, TX 75207-2309

1-800-426-1551 | 715-552-0746

Fax: 715-552-0748

Independent.Review@medworkiro.com

www.medwork.org



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

The claimant has been considered for surgical intervention including in the form of an appeal. Based on a review of the documentation and the ODG guidelines as referenced below, the indications for the proposed surgical intervention are not apparent at this time. Although, at this time, the requested procedure is noted to be an outpatient left shoulder arthroscopic debridement.

Evidence of recent reasonable and comprehensive less invasive treatment including a course of physical therapy have not been documented. The consideration for the arthroscopic debridement procedure is noted; however, the applicable ODG guidelines for debridement of the tenodesis and/or rotator cuff repair do not at this time support the proposed procedure. Again, this is primarily on the basis of a lack of documented and provided comprehensive recent and reasonable non operative treatments including a course of physical therapy and/or other potential and reasonable less invasive treatments.

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)