



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

02/25/2009

DATE OF REVIEW: 02/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee EAU diagnostic arthroscopy w/meniscus tear debridement vs. repair

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. Texas Dept of Insurance Assignment to Medwork 02/05/2009
2. Texas Dept of Insurance notice to URA of assignment of IRO 02/05/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 02/04/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 01/28/2009
6. reconsideration determination letter 01/16/2009
7. notification of determination letter 12/31/2008
8. Progress record 01/27/2009, 12/16/2008, 11/18/2008, 10/14/2008
9. Admission Note 12/16/2008
10. Medical Center Physical Therapy Evaluation 11/18/2008
11. MRI of left knee without contrast 10/06/2008
12. Rehab referral undated
13. Surgery/Procedure Schedule undated
14. Medication list 08/06/1997 – 01/27/2009
15. ODG Guidelines were not provide by URA



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PATIENT CLINICAL HISTORY:

This individual was involved in an injury in xx/xx . Patient subsequently has undergone two arthroscopic procedures in the past. The patient has now had an updated MRI scan. This was carried out on October 6, 2008. There are no fractures. The cruciate ligaments are intact. There is some chondromalacia. There is no evidence of any new meniscal tear.

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

Based upon the Official Disability Guidelines, there is no indication for arthroscopy or meniscal repair. This patient has had previous arthroscopic procedures. There are no new findings. The previous adverse determination should be 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 KNOWLEDGBASE
- 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)