



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)

05/24/2010

MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 05/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right knee arthroscopy, partial meniscectomy vs meniscal repair, possible chondroplasty

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Orthopaedic 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 05/04/2010
2. Notice of assignment to URA 05/04/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 05/03/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 04/26/2010
6. letter 04/01/2010, peer review 03/30/2010, letter 03/23/2010, peer review 03/22/2010
7. Appeal rqst 03/25/2010, 03/19/2010, patient information sheet, medical note 03/17/2010, radiology report 03/03/2010, 05/23/2008, order 05/09/2008, TDI form 04/29/2008
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This patient had work related injury to the knee xx/xx/xx. Records say patient had MRI 2008. Claimant had evaluation 03/17/2010 where the patient states a recent injury while he was pivoting on his right foot. Patient complains of pain in knee both medial and lateral aspects. X-ray of knee show evidence of mild arthrosis at patellofemoral compartment. A recent MRI was carried



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out and compared to study from 2008. There is no instability of the knee. The recommendation now is that the claimant undergoes a right knee arthroscopy, partial meniscectomy vs meniscal repair, possible chondroplasty.

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

Based on the Official Disability Guidelines, the previous adverse determination is upheld. The documentation reviewed does not support the Official Disability Guidelines recommendations. The records reviewed failed to document that conservative treatment or non-operative treatments have been completed; therefore, the medical necessity of the request is not supported and the decision is 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)