

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

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 05/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee arthroscopy/medial meniscectomy/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. Assignment to 05/11/2010
2. Notice of assignment to URA 05/11/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 05/05/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 05/05/2010
6. letter 05/04/2010, 04/19/2010
7. Reconsideration rqst 04/27/2010, letter 04/27/2010, fax rqst 04/06/2010, 01/29/2010, pre-cert rqst 01/22/2010, medical note 10/28/2009, TDI form 10/28/2009, radiology report 09/23/2009, medical note 08/13/2009, work comp ppwk 07/07/2009, medical 04/21/2009
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Claimant is a female with a work injury dated xx/xx/xxxx. This individual continues to complain of left knee pain. MRI showed medial meniscus tear and possible medial collateral ligament sprain. Records indicate that the patient has had physical therapy, an injection, and knee bracing with no improvement. The patient was recommended for surgical intervention to include left knee arthroscopy/medial meniscectomy/chondroplasty.

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

The claimant meets ODG criteria for the requested left knee arthroscopy/medial meniscectomy/chondroplasty. The medical records identify a medial meniscal tear and chondromalacia. The claimant has had conservative management that has failed; therefore the proposed left knee arthroscopy/medial meniscectomy/chondroplasty is reasonable and necessary and fulfills the recommended ODG guidelines. The insurer's decision to deny is overturned.

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)