



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

Workers' Compensation Health Care Network (WCN)

MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 05/03/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 sessions of post-operative PT right knee (97110, 97140, 97035 & 97014)

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

Texas State Licensed MD Board Certified Occupational Medicine physician

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 04/15/2010
2. Notice of assignment to URA 04/15/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 04/09/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 04/09/2010
6. 04/13/2010, MRIoA letter 04/13/2010, 04/12/2010, 03/26/2010, MRIoA 03/25/2010, peer review 02/23/2010
7. Pre-auth 03/24/2010, radiology report 03/16/2010, medical note 03/22/2010, 02/26/2010, 05/20/2009
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

The patient underwent arthroscopic reconstruction surgery for anterior and posterior cruciate ligament tears and medial meniscectomy in July 2007. However, his symptoms were not fully resolved and he continued to seek treatment for his knee pain off and on. On his follow-up evaluation in February 2010, the patient was noted to have findings of medial joint line pain and positive McMurray test. His repeat MRI of the knee, dated March 2010, revealed Grade IV chondromalacia in the medial compartment and lateral meniscal tear. Based on results, it was



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recommended surgery for a lateral meniscectomy and chondroplasty of the patella. In addition, it was also recommended 12 sessions of post-operative PT for the knee.

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

Review records provided state that the right knee surgery (lateral meniscectomy and chondroplasty) was not recommended for the patient due to the lack of trial of any conservative treatment. Based on the Official Disability Guidelines 12 visits of PT over 12 weeks are recommended for post surgical treatment (meniscectomy) of meniscal tear of knee. However, since the patient has not undergone the right knee surgery as of yet, the requested 12 sessions of post-operative PT are not medically indicated at this time; therefore the insurer's decision to deny 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 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)