



Medwork Independent Review

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

11/22/2010

DATE OF REVIEW: 11/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI left knee 73721

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

Texas State Licensed DO Board Certified Physical Medicine & Rehab physician/Pain Management

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 11/02/2010
2. Notice of assignment to URA 11/02/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 11/01/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/29/2010
6. Letter 09/30/2010, 09/14/2010, ur referral 09/24//2010, NCV/EMG 09/07/2010, medical note 09/03/2010, 08/16/2010
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This female sustained a xx/xx/xx , occupational trip and fall injury, landing on her left knee. She underwent a left knee MRI scan demonstrating a large, oblique and horizontal degenerative-type tear involving the body and posterior horn of the medial meniscus. Additionally, there are grade 2 medial compartment chondromalacia changes. There was a small knee joint effusion and grade 2 patellar chondromalacia. Diagnostic x-rays of the left knee demonstrate no evidence of fractures, arthritic changes, or loose bodies. The claimant failed conservative management,



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including physical therapy treatment, and underwent a subsequent left knee arthroscopic partial meniscectomy. She received postoperative physical therapy treatment. Review request is for left knee MRI scan.

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

Based on the Official Disability Guidelines' criteria and the documentation reviewed, the requested MRI left knee is upheld. Review records state that the claimant demonstrates no documented evidence of localized knee pain or any findings suggestive of a focal impairment of the left knee—evidence of instability of the knee or meniscal; therefore, the insurer's decision to deny the requested MRI left knee 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)