



Medwork Independent Review

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MEDWORK INDEPENDENT REVIEW DECISION (WCN)

DATE OF REVIEW: 11/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN dispute

Was the right knee diagnostic arthroscopy with chondroplasty considered medically necessary for this patient?

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 & Spine Surgeon

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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 10/19/2011
2. Notice of assignment to URA 10/18/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 10/19/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/06/2011
6. Insurance 10/04/2011, 09/20/2011
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

The patient had tenderness over the medial femoral condyle with positive McMurray test. There did appear to be recording that the patient had not responded to physical therapy. There is also a record that the patient had tried tramadol and Voltaren gel. The patient had had a knee steroid injection with no relief.

Based upon this information the treatment including diagnostic arthroscopy with chondroplasty was reasonable. The MRI scan did show trace joint effusion. There was mild compartment arthritis and mild patellofemoral changes with arthritis.



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

The previous adverse determination should be overturned. The Official Disability Guidelines would suggest that this was a reasonable procedure for this patient.

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)