



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)

January 18, 2012

DATE OF REVIEW: 1/17/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the right knee arthroscopy with partial medial and lateral meniscectomies deemed 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. Texas Dept of Insurance Assignment to Medwork 12/30/2011
2. Notice of assignment to URA 12/30/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 12/29/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 12/29/2011
6. Appeal review 12/15/2011, medicals 12/15/2011, appeal review 12/05/2011, orthopedic information 11/30/2011, 11/23/2011, workers compensation work status report 11/16/2011, medicals from 11/14/2011, 11/08/2011, 11/03/2011, orthopedic information 11/03/2011, workers compensation work status report 11/3/2011, MRI information 10/27/2011, medicals 10/28/2011, 10/25/2011, 10/24/2011, workers compensation work status report 10/22/2011, 10/21/2011 medicals 10/20/2011, 10/18/2011.

PATIENT CLINICAL HISTORY:



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The patient is a male to have sustained a twisting-loading injury of the right knee. The patient has reportedly, based on a review of the treating provider's records, undergone a course of treatment with physical therapy. The patient has been noted to have persistent pain in the knee without giving way or mechanical issues. The patient has been noted to have tenderness at the medial-greater-than-lateral joint line along with a positive McMurray at the medial joint line. An MRI has revealed evidence of a medical meniscal radial-type tear. The patient has been considered for right knee arthroscopy with partial medial and lateral meniscectomy.

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

As per Official Disability Guidelines, the specific evidence documenting and providing for review evidence of a comprehensive recent trial of the specific medications, and especially the physical therapy records, have reportedly been tried and failed. The patient has undergone other treatment programs which have been unsuccessful

The patient underwent the documented physical therapy at a facility in the Fall, 2011. After reviewing the medical documentation, the references cited, and the standard of care and practices, the requested right knee arthroscopy with partial medial and lateral meniscectomies is considered medically necessary for this patient; therefore, the insurer's denial of these services 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 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



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- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**