



Medwork Independent Review

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

4/30/2012

DATE OF REVIEW: 4/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Home health incision care x4 visits

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 4/10/2012,
2. Notice of assignment to URA 4/10/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 4/10/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 4/10/2012
6. Legal correspondence 4/10/2012, Insurance information 4/6/2012, 3/7/2012, therapy evaluation information 2/29/2012, medical information 2/27/2012, 2/25/2012, operative reports 2/24/2012, medical information 2/24/2012.

PATIENT CLINICAL HISTORY:

The patient has been well documented to be status post a hemiarthroplasty procedure at the age of 60. The patient was noted to have undergone the procedure on 02/24/2012. Diagnosis included that of osteonecrosis of the medial femoral condyle of the left knee. Procedures performed included that of a MAKO hemiarthroplasty. Postoperative care has reportedly occurred due to functional limitations and need for assistive device, difficulty walking and inability to perform self-care and/or wound assessment. Denials have been noted to indicate the



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lack of convincing evidence as to why the individual could not independently ambulate utilizing an assistive device and/or why the individual could not perform wound care.

Home health records were reviewed in detail revealing the need for assistive device, decreased endurance for ambulation, and inability to perform self-care. Incision size was reviewed and the documentation of the dressing changes was reviewed in detail. The condition of the incision was also reviewed as were the vital sign monitoring along with the medication administrations.

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

The applicable ODG guidelines supports that this individual had no adequate competence and/or reasonable ability to perform dressing changes. The procedure performed was an arthroplasty. Should an arthroplasty/partial replacement become infected and/or should early signs of infection and/or for that matter, deep venous thrombosis be not evident as gleaned by the home health nursing, then the results could be that of severe morbidity, at least. The number of home health visits and intensity and type of service performed is within the clinical guidelines for home health care as per ODG and was reasonable and medically necessary to assess optimal postoperative treatment and compliance with same along with to adequately be able to assess early signs of infection and/or blood clots and/or abnormal vital signs and to progress with self-care as per applicable guidelines; therefore, the insurer's denial 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)**