



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: April 28, 2014

Amended Date: May 14, 2014

DATE OF REVIEW: 4/25/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 3xwk x 4wks – left knee.

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

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

PATIENT CLINICAL HISTORY:

The patient was noted to be injured on xx/xx/xx. The left knee was reportedly injured. The patient was treated medically and then surgically at the level of the left knee. The surgical treatment occurred on January 8, 2014. The patient was subsequently noted to have undergone a postoperative course of therapy. The patient postoperatively was also treated with multiple medications. The most recent therapy record as of February 19, 2014 revealed a 50% functional improvement with some residual swelling and range of motion from +3 to 115 degrees of active motion. Strength was noted to be 4 out of 5. The denial letters revealed that clinical findings did not support additional request for 12 visits of therapy on an ongoing formal supervised basis.

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



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The combination of subjective and objective findings support exclusively that a prescribed and self-administered therapy protocol would be exclusive reasonable and medically necessary therapy for this patient. The documentation does not show evidence of any exceptional factors to support a resumption of therapy over and above the 12 visits of physical therapy supported by the ODG criteria. This is based on the applicable ODG guidelines referenced.

The denial of services 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)