



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 7/2/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient surgery for scope of left knee.

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

Texas State Licensed MD Board 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 a male who was noted by injury mechanism to have felt a painful pop in his left knee. The claimant was noted to have been evaluated and treated by the attending physician, who documented restricted activities and treatment with anti-inflammatory medications. The subjective knee pain persisted and there was noted to have been an MRI that revealed grade 4 chondromalacia in the medial compartment and a possible torn medial meniscus. The treating provider records were reviewed in addition to the MRI findings as documented above. The records revealed including as of xxxxx, that the claimant had a consideration for surgical intervention as requested. The findings subjectively and objectively were reviewed. The MRI report of the left knee, dated 04/24/2014, revealed the aforementioned findings including a "small joint effusion." The claimant was noted as of 04/16/2014 to have a height of 70.5 inches and weight of 225 pounds, in addition to otherwise unremarkable findings. On exam, it had been noted that the claimant did have a history of pain, popping, and clicking as noted on 04/15/2014. The subsequent record had revealed on 05/02/2014, that the claimant continued to be symptomatic. Also, denial letters discussed the lack of range of motion deficits and the lack of comprehensive non-operative treatment.



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

At this time, the entire review of documentation does evidence that the claimant has met ODG guideline criteria info. There were no significant motion limitations identified on exam. There was no evidence of any formal supervised physical therapy or treatment with injections. It should be noted therefore that on xxxxx, the left knee did have a 1+ effusion and there was some tenderness of the medial joint line and tenderness at the level of McMurray sign. It was noted that the symptoms had not improved and he was still having "pain, catching, and swelling mostly located in the medial joint."

Therefore, at this time, the claimant has met the intent of the ODG criteria, that there has been persistent subjective and objective findings of mechanical issues with the pain, catching, and swelling. The claimant has failed reasonable non-operative treatments of medications and activity reduction and at this time, surgical intervention for this individual would be considered reasonable and medically necessary, based on the applicable ODG criteria. ODG guidelines had been utilized in this review/report.

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



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- 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)**