



Medwork Independent Review

2777 Irving Blvd, Ste 208

Dallas, TX 75207-2309

1-800-426-1551 | 715-552-0746

Fax: 715-552-0748

Independent.Review@medworkiro.com

www.medwork.org



MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 12/15/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left knee partial medial meniscectomy, tricompartmental synovectomy.

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.

PATIENT CLINICAL HISTORY:

The claimant is a male who was injured approximately XX months ago in XX/XXXX. Reportedly, he had been moving an appliance and felt a painful pop in his knee. He was diagnosed as having internal derangement medial meniscal tear of that left knee. Clinical notes were reviewed. These included the recent appeal letter of denials. The clinical notes reviewed included the MRI of the left knee from XX/XX/XX. There was noted to have been a medial meniscal tear, ongoing pain, swelling, catching, locking, and popping were noted, as well as a knee effusion and moderate medial joint line tenderness. There also was noted to be decreased range of motion, even painful motion of the knee along with a positive McMurray and positive Apley signs. There was noted to be relative right-sided quad atrophy, compared to the left leg. The neurologic exam was noted to be intact. Treatments were noted to have included therapy, altered activity. Medications, cortisone injections, these had all been tried and failed. Denials have been noted to be primarily based on the fact that there was no diagnosis of rheumatoid arthritis. There was an appeals letter that was reviewed, requesting consideration for surgical intervention, included medial meniscectomy and synovectomy of the knee.

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

Despite the lack of diagnosis of inflammatory and/or rheumatoid arthritis, it is evident that this individual has had a persistently painful knee effusion. The failure of reasonable and comprehensive non operative treatments have been well documented. The subjective and



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objective clinical findings correlate with and are corroborated by the MRI scan findings. The individual has persistent synovitis and asymptomatic medial meniscal tear. The applicable clinical guidelines referenced below including ODG Knee Chapter and arthroscopic surgery for cartilage tear and for synovitis have been that this individual has a medical necessity for the aforementioned considered surgical intervention including arthroscopic medial meniscectomy and tricompartmental synovectomy, as overall intent of guidelines have been met.

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)