

February 28, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0478-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in occupational medicine, preventive medicine and public health. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who sustained a work related injury on ___. The patient reported that while at work she was weeding when she fell, striking her anterior right knee on a rock. The patient has had an MRI and X-Rays. The diagnoses for this patient are right knee chondromalacia of patella/patella-femoral osteoarthritis. The patient has been treated with oral pain medications and surgery on September 13, 2001. The patient reinjured her knee approximately two months following her arthroscopic surgery

Requested Services

Repeat MRI.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___ to her right knee. The ___ physician reviewer also noted the patient had been treated with oral pain medications and arthroscopic knee surgery. The ___ physician reviewer further noted that the patient had re-injured her knee approximately two months after arthroscopic surgery on

September 13, 2001. The ___ physician reviewer explained that the patient has had evaluations by several physicians, who have not been able to confirm on examination any internal derangement of the knee that needed work-up by MRI study. The ___ physician reviewer noted that the patient had X-Rays and examinations following the repeat injury. The ___ physician reviewer explained that the evaluations after the repeat injury confirm the pre-existing patellofemoral osteoarthritis and the presence of chondromalacia. The ___ physician reviewer also explained that ligamental disruption that may have occurred after her fall following the surgery on September 13, 2001, should have been notable on physical exam. (Solomon DH et al. Does this patient have a torn meniscus or ligament of the knee: value of the physical examination. JAMA. 2001; 286(13): 1610-1620). The ___ physician reviewer further explained that the focus at this point of the patient's care should be on treatment/rehabilitation, as opposed to further diagnostics. Therefore, the ___ physician consultant concluded that the repeat MRI is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

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I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 28th day of February 2003.