

January 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0516-01

___ 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 ___ external review panel. This physician is board certified in orthopedic surgery. ___ 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 42 year-old male who sustained a work related injury to his left knee on ___. The patient reports that while at work on ___ he sustained a twisting type injury to his left knee. The patient has had knee surgery on 10/24/00, 2000, 2001, and 2002. This patient's diagnoses include, status post left knee anterior cruciate ligament reconstruction with multiple debridements, chondromalacia medial compartment with significant medial compartment collapse.

Requested Services

Revision Arthroscopic ACL Reconstructive Left Knee Surgery.

Decision

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

Rationale/Basis for Decision

___ physician reviewer indicated that the patient underwent ACL reconstruction approximately 4 weeks post the work related injury on ___. ___ physician reviewer also indicated that the patient has undergone multiple procedures for removal of debris and has also been noted to have a significant degree of arthrosis. ___ physician reviewer noted that a second opinion was

performed and although it was noted that the patient had significant post-traumatic changes in the knee, a repeat ACL reconstruction was not indicated for this patient. ___ physician reviewer explained that the patient has significant underlying arthrosis. However, ___ physician reviewer also explained that there is no evidence of appreciable functional instability secondary to ACL insufficiency. ___ physician reviewer further explained that there is not enough clinical evidence of instability requiring a repeat ACL reconstruction. Therefore, ___ physician consultant concluded that a revision arthroscopic ACL reconstructive left knee surgery is not medically necessary for the treatment of this patient's condition.

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 23st day of January 2003.