

May 28, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0806-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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 orthopedic surgery. The ___ 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, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a gentleman who sustained a work related injury on ___. The patient reported that while at work he was carrying a log weighing over 60 pounds when he missed his step and felt pain in his left knee. The patient underwent X-Rays, MRI and then left knee surgery on 8/4/02. The patient has been treated with post surgical physical therapy and referred for work hardening. The diagnoses for this patient include internal derangement, possible medial meniscal tear of the left knee.

Requested Services

Work Hardening.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a gentleman who sustained a work related injury to his left knee on ___. The ___ physician reviewer also noted that the work related injury included the medial meniscus tear.

The ___ physician reviewer explained that there is some evidence that postoperative knee patients respond well to therapy in general. (Thomson LC, Handoll HH, Cunningham A, Shaw, PC. Physiotherapist-led programmes and interventions for rehabilitation of anterior cruciate ligament, medical collateral ligament and meniscal injuries of the knee in adults. Cochrane Database Syst Rev 2002;(2):CD001354). The ___ physician reviewer also explained that there is further evidence from prospective studies that patients status post meniscal surgery have a better, faster recovery with therapy. (Moffet H, Richards CI, Malouin F, Bravo G, Paradis, G. Early and intensive physiotherapy accelerates recovery post arthroscopic meniscectomy: results of a randomized controlled study. Arch Phys Med Rehabil 1994 Apr;75(4):415-26. Vervest AM, Maurer CA, Schambergen TG, de Bie, RA, Bulstra, SK. Effectiveness of physiotherapy after meniscectomy. Knee Surg Sports Traumatol Arthrosc. 1999; 7(6): 360-4). The ___ physician reviewer further explained that in both studies quoted regarding therapy for meniscal procedures, the time period of therapy was three weeks (around nine visits). The ___ physician reviewer explained that there is no evidence that the patient's condition has been fully re-assessed. The ___ physician reviewer also explained that further assessment and either treatment or acceptance of limitations based on that assessment is reasonable at this time. Therefore, the ___ physician consultant concluded that the requested work hardening 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,

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 May 2003.