

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 28, 2003

MDR Tracking #: M2-03-1407-01

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant sustained an injury on ___, when she missed the last step as she descended a ladder while carrying a radiator. She landed on her feet, but fell backwards, with the radiator falling on her knees. She underwent X-rays on that day. These revealed degenerative changes, but no apparent fracture. She was evaluated by ___ after two weeks, and an MRI of the right knee was ordered shortly afterwards. The MRI revealed a lateral meniscus tear, degeneration and possible intrasubstance tear of the medial meniscus, degenerative changes in the medial joint, and a small subchondral cyst in the lateral tibial condyle. She was referred to ___, who recommended arthroscopy. At arthroscopy on 12/20/01, she was noted to have an extensive degenerative-type tear of the medial meniscus with grade I-II chondromalacia of the medial femoral condyle, an extensive bucket-handle tear of the lateral meniscus, and a focal grade IV area of chondromalacia on the lateral femoral condyle. Postoperatively, she continued to have pain. (She also developed an ulcer in a popliteal burn scar, which was treated by scar revision and skin grafting on 5/14/02). A total knee arthroplasty has been recommended.

Of note, her past medical history is significant for a burn to the thigh at the age of 5, (treated with skin grafting), fractures of both femurs (treated on the right with an intramedullary nail) and a left total knee arthroplasty.

Requested Service(s)

Approval for a right total knee arthroplasty has been requested. A preoperative plastic surgery consultation has also been requested.

Decision

I disagree with the insurance carrier and find the requested services medically necessary.

Rationale/Basis for Decision

A total knee arthroplasty appears indicated for the degree of arthritis described. In light of the difficulty with the popliteal scar in the past, a plastic surgery consultation in preparation for the surgery also appears appropriate. The incident described, however, in all probability represents an aggravation or acceleration of preexisting arthritis, rather than the initial cause of this arthritis.

Although the claimant notes that she did not have knee pain prior to the injury, osteophyte formation and joint space narrowing is noted on X-rays. Grade 4 chondromalacia was noted arthroscopically 2 months after the incident. Most likely, the claimant had a degree of arthritis in her knee which may have been rendered symptomatic by the incident.

Of note, I have not had opportunity to review the initial accident report, the report from the initial hospital visit, the majority of ___ notes, or notes from her treatment preceding the date of injury. Quite possibly, these may provide helpful information regarding the degree of symptomatology reported by the claimant at those times.

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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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)).

This decision by the IRO is deemed to be a TWCC decision and order.