

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

September 17, 2003

**Re: IRO Case # M2-03-1689**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 48-year-old female who was injured on \_\_\_. The injury reportedly occurred over a period of time with gradual onset. The patient operated a sewing machine, and began experiencing left-sided leg pain, knee pain and low back pain. The patient presented to a chiropractor on 7/26/02, and was referred to an orthopedic surgeon who evaluated her on 2/26/03. The patient was reported to have a normal left knee exam with probable referred pain from the lower back. A 3/15/03 MRI of the left knee indicated a small 1.0 cm ganglion cyst just behind the PCL and grade II degenerative changes in the posterior horn of the medial meniscus. The lateral meniscus was noted to be intact. Plain radiographs done on the same day were normal. The orthopedic surgeon reviewed the MRI and concluded that the patient's pain is due to the presence of a ganglion cyst. He recommended surgery for the left knee.

Requested Service(s)

Knee arthroscopy/lateral meniscectomy & arthrotomy w removal of poplitea cyst

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

Based on the records provided for this review, the clinical evidence to support therequested procedure is poor. A normal knee exam is noted on 2/26/03. On 3/26/03 a positive McMurray's test on the lateral side of the patient's knee is noted. The MRI report demonstrated an intact lateral meniscus with no evidence of pathology. The MRI also demonstrated a very small ganglion cyst just posterior to the PCL. Ganglion cysts in the popliteal region of the knee can be the result of a degenerative process in the knee, or due to some internal derangement, however, they can also be an incidental finding of undetermined etiology. Based on the documentation provided, it is unlikely in this case that this 1.0 cm cyst is the cause of the patient's knee pain. There is poor clinical evidence to support this conclusion. It is not usually recommended to excise a ganglion cyst in the popliteal region of the knee unless the cyst is large or palpable.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 18<sup>th</sup> day of September 2003.