

October 15, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-0036-01**

\_\_\_ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 male who sustained a work related injury on \_\_\_. The patient reported that while at work he injured his left knee and left leg. The diagnoses for this patient have included post left knee surgery and left knee internal derangement syndrome. The patient has undergone bilateral lower extremity EMG/NCV and an MRI of the left knee. The patient underwent arthroscopy of the knee on 2/3/03 and has also been treated with injections of the knee, physical therapy and pain medications.

### Requested Services

Repeat Left Knee MRI.

### 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 male who sustained a work related injury to his left knee on \_\_\_. The \_\_\_ physician reviewer explained that an MRI of the left knee had been performed preoperatively to the left knee arthroscopy on 2/3/03. The \_\_\_ physician reviewer noted that postoperatively the patient has been treated with injections, therapy and analgesics. The \_\_\_ physician reviewer indicated that an examination from 7/1/03 noted that the patient was still having pain over the medial and lateral aspect of the knee, there was still pain upon limitation of flexion and extension, varus and valgus negative and slight laxity on the lateral aspect of the knee extending into the left calf. The \_\_\_ physician reviewer also noted that an examination from 7/22/03 noted that the current diagnoses for this patient include post left

knee surgery and left knee internal derangement syndrome. The \_\_\_ physician reviewer explained that the patient continues to complain of pain upon flexion and extension of the left knee. The \_\_\_ physician reviewer noted that the treating physician has recommended a repeat MRI with and without contrast to further elucidate the patient's possible internal derangement. The \_\_\_ physician reviewer explained that the patient underwent left knee arthroscopy on 2/3/03. The \_\_\_ physician reviewer also explained that any internal derangement would have been corrected during this surgery. The \_\_\_ physician reviewer indicated that there is no evidence of repeat injuries between 2/3/03 and 7/1/03 that would substantiate the need for an additional MRI. Therefore, the \_\_\_ physician consultant concluded that the requested repeat MRI of the left knee 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/Appeals Clerk  
P.O. Box 17787  
Austin, TX 78744  
Fax: 512-804-4011

**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 15<sup>th</sup> day of October 2003.