

October 30, 2003

David Martinez
TWCC Medical Dispute Resolution
MS-48
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Austin, TX 78744-1609

MDR Tracking #: M2-04-0253-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ is a 54-year-old welder who tripped over an electric wire while at work on ___ and twisted his knee. He was found to have a tear in his medial meniscus. A preliminary MRI of the knee demonstrated the tear as well as some degenerative changes in his knee. He was felt to be a candidate for surgical treatment of the torn meniscus. He was taken to surgery and arthroscopically ___ did a partial medial meniscectomy along with some other debridement in his knee for degenerative joint disease. Following surgery, the patient did not get a good response. He continued with swelling and pain in his knee and tried various anti-inflammatory medications from which he did not get any response. An unloader brace was obtained for him, but this did not help.

His knee pain continues to be quite severe. This has continued for over one year and a repeat MRI was done on May 4, 2003. This repeat MRI reported irregular appearance in the posterior horn of the medial meniscus with some increased signal in the medial meniscus along with some degenerative changes. Because of the total failure of conservative treatment, ___, an orthopaedic surgeon, has recommended arthroscopic examination of this patient's knee with debridement of the meniscus and further synovectomy and chondroplasty on the knee as indicated at the time of surgery. This request for arthroscopic surgery has been denied by the carrier.

REQUESTED SERVICE

Arthroscopic examination of the knee with debridement of the meniscus and further synovectomy and chondroplasty is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Since all other conservative measures have failed to give any relief to ____, it is reasonable to do an arthroscopic debridement of his knee. He has been a year and a half since his previous procedure and his symptoms have not improved.

____ MRI demonstrates an irregular appearance of the medial meniscus with increased signal in that area which could mean a tear in the meniscus in that area. It is known that this gentleman has degenerative arthritis of the knee, but there is very little else that could be offered him short of a total knee replacement other than another synovectomy and debridement arthroscopically. The reviewer agrees with the proposed treatment as requested by ____.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 30th day of October 2003.