

January 26, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter**

MDR Tracking #: M2-04-0586-01

___ 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 39 year-old male who sustained a work-related injury on ___. The patient reported that while at work he slipped and fell off a ladder sustaining an injury to his low back, hip and left knee. The patient was initially evaluated at a medical center where he underwent X-Rays of his left knee and treated with oral medications. An MRI of the left knee dated 12/15/00 indicated a suspected posterior horn medial meniscus tear and small synovial effusion. The patient began a three-month course of physical therapy on 10/16/00. On 2/13/01, the patient underwent arthroscopic surgery of the left knee, partial excision of medial meniscus, chondroplasty of the patella and medial femoral condyle, and two-compartment synovectomy. On 5/7/01 the patient underwent a left knee MRI that showed patellar tendinitis and intrasubstance tear of posterior cruciate ligament. The diagnoses for this patient have included knee sprain/strain and lumbar sprain/strain.

Requested Services

MRI of the left knee

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 39 year-old male who sustained a work related injury to his low back, hip and left knee on ___. The ___ physician reviewer also noted that on 2/13/01 the patient underwent arthroscopic surgery of the left knee, partial excision of medial meniscus, chondroplasty of the patella and medial femoral condyle, and two compartment synovectomy.

The ___ physician reviewer further noted that the patient underwent a repeat MRI of the left knee on 5/7/01 that showed patellar tendonitis and intrasubstance tear of posterior cruciate ligament. The ___ physician reviewer indicated that a repeat MRI of the left knee would not influence subsequent postoperative treatment. 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 26th day of January 2004.