

NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 25, 2004

RE: MDR Tracking #: M2-04-0739-01
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 reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The 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 has a history of chronic left knee pain allegedly related to a compensable work injury that occurred on ___. The claimant has undergone arthroscopic meniscectomy and most recently an open lateral release and medial plication on 3/5/03 for a diagnosis of lateral patellar subluxation.

Requested Service(s)

Left knee laser arthroscopy

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Upon review of all documentation provided, there is no clear evidence of surgical indication. MRI report dated 9/19/03 documents degenerative signal changes in the medial meniscus with no tear demonstrated. The most remarkable finding of the MRI is abnormal appearance of patellar tendon suggesting chronic patellar tendonitis. There is no documentation of clinical instability. There is no documentation of patellofemoral subluxation. There is no documentation of exhaustion of conservative measures of treatment including but not limited to oral nonsteroidal and steroidal anti-inflammatory medications, bracing, physical therapy and injections. I strongly recommend continued conservative management in this clinical setting.

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) 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.