

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO: 453-04-7261.M2

June 9, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1320-01

___ 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 and is familiar with the condition and treatment options at issue in this appeal. 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 49 year-old female who sustained a work-related injury on ___. The patient reported that while at work she slipped and fell, injuring her right knee and right shoulder. The diagnoses for this patient have included shoulder impingement-right, rotator cuff tear-right, and medial meniscus tear-right. On 9/30/02 the patient underwent a right knee arthroscopy and on 12/02/02 the patient underwent a right shoulder arthroscopy. Pre and postoperatively the patient had been treated with shoulder and knee injections, physical therapy and oral anti-inflammatories. The patient underwent a MRI of the right knee and shoulder on 8/20/03 that was reported to have shown some acromioclavicular fibrosis and no evidence of meniscus or ligament tears.

Requested Services

Right total knee arthroplasty.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Initial Medical Report 8/13/02
2. MRI Report 8/20/03

Documents Submitted by Respondent:

1. Orthopedic Consult 3/18/04

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 49 year-old woman who sustained a work related injury to her right knee and right shoulder on ___. The ___ physician reviewer also noted that the patient subsequently underwent two arthroscopic surgeries consisting of arthroscopy of the knee on 9/30/02 and right shoulder surgery performed on 12/2/02. The ___ physician reviewer indicated that the patient underwent a right knee MRI on 10/10/03 due to persistent symptomatology that revealed scar tissue, mild hypertrophic DJD of the knee joint compartment, myxoid changes and postoperative changes. The ___ physician explained that at the time of the surgery for the right knee, the patient did not experience appreciable mechanical issues with her menisci but that moderate chondromalacia was noted. The ___ physician reviewer also explained that the documentation provided did not clearly indicate what types of non-operative and/or conservative management has been tried other than three knee injections. The ___ physician reviewer explained that the patient is very young and total knee replacements have limited longevity. The ___ physician reviewer further explained that the degree of this patient's disease does not require a total knee replacement. Therefore, the ___ physician consultant concluded that the requested right total knee arthroplasty 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 9th day of June 2004.