

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** August 16, 2004

**RE: MDR Tracking #:** M2-04-1580-01  
**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 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.

### **Submitted by Requester:**

- Notes from \_\_\_ dated 2-24-04 and 4-29-04 regarding the knee injury of \_\_\_\_
- Retrospective peer review 1-7-04 by \_\_\_ Orthopaedic Surgeon and \_\_\_ medical director \_\_\_.
- Notes from \_\_\_ regarding her knee injury.

### **Submitted by Respondent:**

- Peer review 6/24/04 from \_\_\_ regarding a back injury from \_\_\_\_
- Notes and letter from \_\_\_ regarding the back injury of \_\_\_\_
- Notes from \_\_\_ regarding the back injury

### **Clinical History**

This is a 47 year old female who sustained a twisting injury to her right knee on \_\_\_\_. She had an MRI that showed arthritic changes and degenerative changes according to the \_\_\_ peer review. The MRI report is not included in the documentation. She subsequently had an arthroscopy with partial medial meniscectomy and release of a plica in July 2003. She continues to complain of medial knee pain. She was seen by \_\_\_ who noted quadriceps atrophy and weakness. Also noted was an effusion and a positive Apley grind test. A second MRI was requested.

**Requested Service(s)**

MRI of right knee

**Decision**

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

**Rationale/Basis for Decision**

The claimant had documented arthritis in her knee at the time of injury as indicated on the first MRI. It is common to have arthritic symptoms after partial medial meniscectomy in arthritic knees. There is no documentation that x-rays were done especially weight bearing anteroposterior both knees, and there is no mention on examination by \_\_\_ of her knee alignment especially weight bearing. \_\_\_ examination is compatible with a post meniscectomy arthritic knee. She should be treated accordingly. The arthritis is a pre-existing condition. There are no clinical indications at this time for an MRI of her right knee.

**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.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 22<sup>nd</sup> day of June 2004.