

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 23, 2004

RE: MDR Tracking #: M2-04-1717-01
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.

Submitted by Requester:

- Designated doctor evaluation report by ___
- Operative report 1/22/04, ___
- Clinic notes, 12/12/03-7/14/04, ___

Submitted by Respondent:

- ___ pre-authorization denials dated 6/25/04 and 7/5/04
- Copy of MMR-117 dated 7/30/04
- Copy of TWCC-60 from injured worker
- Copy of MR-100 from TWCC dated 7/21/04

Clinical History

The claimant is a 39 year old gentleman who incurred injury on ___. The claimant had an injury in ___ which required left knee surgery and a second surgery of the left knee in 2003. On 1/22/04, left knee arthroscopy showed chondromalacia of the medial femoral condyle. The claimant had a partial medial meniscectomy and partial lateral meniscectomy. The claimant continues to have bilateral joint line tenderness more prominent in the medial compartment.

Requested Service(s)

Left knee arthroscopy, unicondylar replacement.

Decision

I agree with the insurance carrier that the services in dispute are not medically necessary.

Rationale/Basis for Decision

The claimant is a 39 year old male who is status post partial medial and lateral meniscectomies. The above procedure is not indicated given the claimant's young age and previous history of multiple surgeries which included 3 surgeries to his left knee and lateral meniscectomy. The claimant would not have long term success with the requested procedure given his young age as the need for revision of the arthroplasty will be high. As a result the claimant is not a candidate for left knee unicondylar replacement.

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 24th day of August 2004.