

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

SOAH DOCKET NO. 453-05-0965.M2

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 8, 2004

RE: MDR Tracking #: M2-04-1782-01
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:

- Clinical documentation by work conditioning and management performed by ___
- Clinical note dated 6/15/04 by ___

Submitted by Respondent:

- Peer review letter dated 8/16/04
- Clinical notes of ___
- Clinical notes of ___
- MRI report dated 11/25/02
- Required medical examination report by ___ dated 1/30/03

Clinical History

The claimant has a history of chronic right knee pain allegedly related to a work compensable injury that occurred on ___. There is an alleged slip and fall injury. The claimant was managed conservatively. An MRI report dated 11/25/02 documents no evidence of meniscus tear and a

Grade I signal within the posterior horn of the medial meniscus, abnormal signal within the proximal side of the anterior cruciate ligament.

Requested Service(s)

Diagnostic arthroscopy and proposed medial meniscus debridement, arthroscopic lateral release.

Decision

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

Rationale/Basis for Decision

Generally, meniscectomy is indicated in the presence of objective evidence of meniscus tear. There is no objective evidence of meniscus tear provided. According to the clinical report dated 6/15/04, there is no documentation of effusion, no documentation of a positive McMurray's test, no documentation of significant deficits in range of motion, and no documentation of mechanical symptoms suggesting a meniscus tear. Previous MRI report is referred to and a Grade I signal within the meniscus is not objective evidence of meniscus tear. There is no documentation of exhaustion of conservative measures in treatment including, but not limited to, physical therapy, bracing, and intra-articular cortisone injections. Generally a lateral release is indicated for clinically documented patellar instability after failure and exhaustion of usual and customary conservative measures of treatment including aggressive quad rehabilitation and bracing. There is no objective documentation of patellar instability. There is no discussion of functional Q-angle. There is no documentation of merchant's view x-rays with appropriate measurements. There is no documentation of a positive patellar grind. There is no documentation of exhaustion of conservative measures of treatment including aggressive quad rehabilitation and bracing. Continued appropriate conservative management is strongly recommended 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.

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 8th day of September 2004.