

IRO America Inc.

An Independent Review Organization

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Amended November 9, 2005

October 26, 2005

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____

TDI-DWC #: _____

MDR Tracking #: _____

M2-05-2307-01

IRO #: _____

5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed M.D., board certified and specialized in Orthopedic Surgery. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, medical records from Requestor, Respondent, and Treating Doctor (s), including:

MRI left knee, 09/27/04

Office note, Dr. Jarolimek, 10/15/04, 11/15/04, 05/26/05, 07/25/05

OR report, 01/17/05

Chiropractic evaluation and treatment, 02/08/05

Chiropractic physical performance test, 02/09/05, 03/09/05, 04/12/05, 05/10/05

Medical evaluation 05/18/05
Letter by attorney of representation, 08/24/05
Form stating carrier denying total knee replacement by DD exam
Peer reviews, 06/14/05 and 07/01/05
Appeal for total left knee arthroplasty, 06/28/05

CLINICAL HISTORY

The Patient is a 63 year old male who twisted his left knee at work on _____. An MRI dated 09/27/04 revealed advanced osteoarthritis of the medial compartment, tears of the medial and lateral meniscus, effusion and chondromalacia. X-rays dated 10/04/04 documented complete obliteration of the medial joint space. Dr. Jarolimek prescribed non-steroidal anti-inflammatory medication and active rehabilitation after injecting the knee. The Patient underwent a partial lateral and medial meniscectomy and chondroplasty of the femoral trochlea on 01/17/05. Postoperatively, The Patient obtained chiropractic physiotherapy and regained left knee motion of zero to 134 degrees. A medical evaluation on 05/18/05 determined that The Patient had reached maximum medical improvement with a 4 percent impairment rating as of that date.

The Patient has remained under Dr. Jarolimek's care with continued left knee pain despite surgery and rehabilitation. On 05/26/05 Dr. Jarolimek injected the knee and documented range of motion of full extension to 110 degrees flexion and quadriceps atrophy. Dr. Jarolimek recommended that The Patient undergo a left total knee replacement.

DISPUTED SERVICE(S)

Under dispute is prospective and/or concurrent medical necessity of Total left knee arthroplasty with a three-four day length of stay, purchase of Cryotherapy unit, and continuous passive motion unit rental times two weeks

DETERMINATION/DECISION

The Reviewer partially agrees with the determination of the insurance carrier.

- The left total knee arthroplasty with a 3-4 day stay is medically necessary.
- The cryotherapy unit is not recommended as medically necessary.
- The rental of a CPM machine is appropriate and medically necessary.

RATIONALE/BASIS FOR THE DECISION

The total knee arthroplasty is certainly indicated. It has nothing whatsoever to do with The Patient's injury of _____. The Patient had extensive pre-existing degenerative joint disease that pre-dated his September 2004 injury. That injury did not advance his arthritic condition significantly and there is nothing to indicate that The Patient would have a need for the total knee arthroplasty. Because of that injury was going to need the total knee arthroplasty whether The Patient had the injury in 2004 or not. Again, the total knee arthroplasty is indicated and would be a reasonable treatment, but it is not medically necessary as a result of the _____ injury. The three to four day length of stay is reasonable if the knee arthroplasty is performed. The Cryotherapy unit is not medically necessary because less intensive treatments are available and as effective. The continuous passive motion unit rental for two weeks is reasonable after a total knee arthroplasty. Again, none of these are related to the _____ injury.

Screening Criteria

1. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following:

Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer

Cc: _____

Service Lloyds Ins. Co.
Attn: Robert Josey
Fax: 512-346-2539

Lubor Jarolimek
Fax: 713-521-1148

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the DWC via facsimile, U.S. Postal Service or both on this 26th day of October, 2005.

Name and Signature of IRO America Representative:

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer