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NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 2, 2005

Requester/ Respondent Address:

TWCC
Attention: ____
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

Dr. H, DC
Attn: ____
Fax: 713-468-0680
Phone: 713-468-8085

CNA
Attn: ____
Fax: 713-295-6022
Phone: 713-663-5323 x 6669

RE: Injured Worker:

MDR Tracking #: M2-05-0551-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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:

- Clinical documents from the Orthopedic and Joint Replacement Center dated 9/2/03, 11/7/03, 3/15/04, 8/4/04, 10/11/04
- MRI of left knee report dated 11/14/03
- Operative report of surgery performed on the left knee dated 1/22/04

Submitted by Respondent:

- Peer review dated 10/28/04
- Peer review appeal dated 11/17/04
- IME by Dr. Robert E. Whitsell, M.D. dated 4/19/04

Clinical History

The claimant has a history of chronic left knee pain allegedly related to a compensable injury that occurred on or about _____. The claimant allegedly fell onto knees and hands. MRI report dated 11/14/03 indicates probable contusion superimposed upon a bipartite patella, bone bruise and small effusion. The claimant ultimately underwent a partial patellectomy on 1/22/04. This procedure was carried out through a small arthrotomy and closed with Ethibond suture. The claimant now has suture line pain.

Requested Service(s)

Left knee arthrotomy with removal of suture laterally.

Decision

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

Rationale/Basis for Decision

Generally Ethibond suture is resorbed slowly over time. The claimant exhibits a full functional range of motion according a clinic note dated 3/15/04. There is no documentation of mechanical symptoms or significant internal derangement that would necessitate arthrotomy and removal of foreign body. There is no documentation of recurrent effusion to indicate any significant internal derangement necessitating a repeat arthrotomy. A repeat arthrotomy may precipitate a worsening of the condition. I strongly recommend continued conservative management 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 2nd day of February 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: