

# IRO America Inc.

## An Independent Review Organization

(IRO America Inc. was formerly known as ZRC Services Inc. DBA ZiroC)

**7626 Parkview Circle**

**Austin, TX 78731**

Phone: 512-346-5040

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July 8, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: \_\_\_\_\_

TWCC #: \_\_\_\_\_

MDR Tracking #: M2-05-1792-01

IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission (TWCC) has assigned this case to IRO America for independent review in accordance with TWCC 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 MD, board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC 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 any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the 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 and information from the Respondent, including:

1. Disability note, 02/19/03
2. Office notes, Dr. Bean, 02/03/04, 02/04/04, 06/08/04, 03/08/05, and 04/12/05
3. Activity log notes, 03/25/05
4. Letter to claimant regarding non-authorization or procedure, 03/30/05
5. left knee MRI, 04/14/05

6. pre-authorization review, Dr. Brooks, 04/21/05
7. Letter to claimant regarding denial, 04/27/05
8. Medical dispute resolution request/response form, 05/12/05
9. peer review, 05/23/05

### **CLINICAL HISTORY**

The claimant is a 52-year-old male injured on \_\_\_\_\_. Dr. Bean saw him on 03/08/05 with complaints of left knee pain. X-rays reportedly revealed significant arthritis and shift of the left knee. His most recent exam findings of 04/12/05 revealed tenderness over the medial and lateral aspect of the knee. A left knee MRI done on 04/14/05 revealed progressive edema of the posteromedial tibial plateau, progressive maceration of the medial meniscus and hypertrophic changes and severe chondromalacia of the patellofemoral medial compartment. A left total knee arthroplasty has been requested, denied, and now appealed.

### **DISPUTED SERVICE(S)**

Under dispute is the prospective and/or concurrent medical necessity of prospective left total knee arthroplasty.

### **DETERMINATION/DECISION**

The Reviewer agrees with the determination of the insurance carrier.

### **RATIONALE/BASIS FOR THE DECISION**

Based solely on the records provided by the request, the left total knee arthroplasty is not recommended as medically necessary. According to the records the claimant has medial and lateral knee tenderness with x-rays showing osteoarthritis. A recent MRI revealed severe chondromalacia of the patellofemoral medial compartment. However, there is no documentation regarding conservative treatment specific to the left knee. This treatment would be expected to include physical therapy, medication, activity modification, cortisone injection and possible visco supplementation. While surgical intervention could be appropriate for this claimant with significant arthritis of his left knee, the medical records provided do not support the procedure at this time based on a lack of a course of conservative treatment.

### **Screening Criteria**

#### 1. Specific:

Orthopedic Knowledge Update 8, Chapter 38, pages 457-459

#### 2. 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 TWCC 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 TWCC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**

Cc: [Claimant]

Claims Administrative Services

Attn: Linda Madsen

Fax: 903-509-1888

**YOUR RIGHT TO REQUEST A HEARING**

Either party to 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.

Name/signature

**I hereby certify, in accordance with TWCC 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 TWCC via facsimile, U.S. Postal Service or both on this 7<sup>th</sup> day of July, 2005.**

**Name and Signature of Ziroc Representative:**

Sincerely,  
**IRO America Inc.**  
  
Dr. Roger Glenn Brown  
**President & Chief Resolutions Officer**