

NOTICE OF INDEPENDENT REVIEW DECISION

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September 12, 2005

Requestor

Respondent

Old Republic Insurance
ATTN: Neal Moreland
Fax#: (512) 732-2404

RE: Injured Worker:
MDR Tracking #: M2-05-1904-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 a TMF physician reviewer who is board certified in Orthopedic Surgery, by the American Board of Orthopaedic Surgery Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1969, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 43 year-old female injured her left knee on ___ while performing her usual duties at her place of employment. She has been treated with medications and surgery.

Requested Service(s)

Left knee CTI-OA-L1858 knee brace with straps (PCL-Posterior Cruciate Ligament)

Decision

It is determined that there is medical necessity for the left knee CTI-OA-L1858 knee brace with straps (PCL-Posterior Cruciate Ligament) to treat this patient's medical condition.

Rationale/Basis for Decision

This patient suffered a torn Posterior Cruciate Ligament (PCL) of her left knee and a medial meniscus tear in a fall at work. Arthroscopy of the left knee revealed the PCL tear and she exhibits physical finding consistent with such an injury. Bracing to prevent PCL instability is not unreasonable. Therefore, the requested left knee CTI-OA-L1858 knee brace with straps (PCL) is medically necessary to treat this patient's medical condition.

This decision by the IRO is deemed to be a TWCC decision and order.

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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,



Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

cc: Program Administrator, Medical Review Division, TWCC

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 carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 12th day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Used by TMF in Decision

Patient Name:

TWCC ID #: M2-05-1904-01

Medical record documentation provided:

- **Progress Notes**