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NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 2, 2005

Requester/ Respondent Address: TWCC
Attention: Rebecca Farless
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

L & W Orthopaedic Associates
Attn: Pat Reeves
Fax: 972-498-4939
Phone: 972-498-8602

The Hartford
Attn: Barbara Sachse
Fax: 512-343-6836
Phone: 512-343-8310

RE: Injured Worker:
MDR Tracking #: M2-05-2001-01
IRO Certificate #: IRO 5263

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 of L & W Orthopaedic Associates
- MRI report of the left knee by Southwest Imaging and Interventional Specialists, PA

Submitted by Respondent:

- Peer review from The Hartford Underwriters Insurance Company dated 4/26/05
- Appeal from The Hartford Underwriters Insurance Company dated 5/10/05
- Clinical documents of L & W Orthopaedic Associates
- MRI report of the left knee by Southwest Imaging and Interventional Specialists, PA dated 4/14/05

Clinical History

The claimant has a history of left knee pain allegedly related to a compensable injury that occurred on or about _____. The claimant is status post arthrotomy with open meniscectomy 30 years ago. X-rays document complete loss of the cartilage space of the left knee.

Requested Service(s)

Left knee arthroscope with meniscectomy

Decision

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

Rationale/Basis for Decision

Generally endstage arthritis of the knee with radiographic evidence of complete loss of cartilage space (“bone on bone”) is treated by conservative measures until unremitting pain leads to a decision for surgical intervention in the form of joint reconstruction (total knee arthroplasty). The claimant has evidence of pre-existing severe arthritis of the left knee. The claimant has undergone an arthrotomy with subtotal meniscectomy 30 years ago. The mechanism of injury and past medical history suggest an aggravation of pre-existing arthritis of the left knee. Radiographs and MRI confirm severe advanced osteoarthritis of the knee and the patellofemoral joint with complete loss of the articular cartilage of the medial compartment. There is no documentation of exhaustion of conservative measures of treatment including but not limited to oral nonsteroidal anti-inflammatory medications, bracing, physical therapy and joint fluid replacement. There is no documentation to support the medical necessity of an arthroscopic procedure in this clinical setting. There is no support in the literature to indicate that an arthroscopic debridement would significantly alter the natural history of the claimant’s pre-existing disease process.

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 August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder