

# IRO America Inc.

## An Independent Review Organization

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June 1, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

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

TDI-DWC #: \_\_\_\_\_

MDR Tracking #:

M2-06-1201-01

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 MD, 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, records from the Requestor, Respondent, and Treating Doctor(s), including:

- Office visit, 01/25/05, 02/10/05, 03/29/05, 05/13/05, 06/17/05, 07/01/05, 07/15/05, 08/03/05, 08/24/05, 09/14/05, 09/28/05, 10/12/05, 10/26/05, 11/09/05, 11/23/05, 12/13/05, 02/08/06, 03/03/06, 03/20/06, 03/29/06, 04/05/06
- MRI, left ankle, 02/17/05
- Operative report, 06/02/05
- Consultation, infectious disease, 08/04/05
- Discharge summary, 08/06/05

- Consultation, pain management, 10/21/05
- Procedure, lumbar block, 11/10/06, 12/29/05, 02/23/06, 04/20/06
- Independent medical evaluation, 01/04/06
- Three phase bone scan, 02/01/06
- Peer review, 03/06/06, 03/13/06
- Medical review, Dr. Bucks, 04/24/06

### **CLINICAL HISTORY**

This 31 year old \_\_\_\_\_ had a reported twisting injury to the left knee in \_\_\_\_\_ and underwent a left knee arthroscopy with a partial lateral meniscotomy in June 2005. The Patient reported swelling, pain and redness on a 08/03/05 physician visit which required hospital admission for cellulitis of the left knee. The records indicated that The Patient then went on to develop possible regional sympathetic dystrophy. In addition, modularity in the fat pad was noted on a 09/28/05 examination. Referral for evaluation for regional sympathetic dystrophy was recommended before proceeding with an arthroscopy and excision of the fat pad.

The Patient treated under a pain management specialist for the diagnosis of regional sympathetic dystrophy and underwent several lumbar sympathetic blocks with significant relief. A bone scan was then done on 02/01/06 which showed no evidence of infection and not a classic appearance of regional sympathetic dystrophy.

A 02/08/06 physician examination revealed The Patient with persistent clicking in the left knee and continued left lower extremity mottled appearance. Allodynia was noted. A follow up physician visit dated 03/03/06 noted The Patient with problems with feeling of popping at the fat pad.

A medical review done on 04/24/06 gave the opinion that The Patient did not carry a diagnosis of regional sympathetic dystrophy, but The Patient did meet the criteria for chronic pain syndrome.

This is a request for a medical dispute resolution for a left knee arthroscopy with excision of a fat pad.

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

Under dispute is the prospective, and/or concurrent medical necessity of left knee arthroscopy with excision of fat pad.

### **DETERMINATION/DECISION**

The Reviewer agrees with the determination of the insurance company.

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

The Reviewer does not recommend the proposed knee arthroscopy with excision of fat pad as being medically necessary for This Patient. There is no evidence that this will improve Patient's condition in any significant way and if she does have complex regional pain syndrome or reflex sympathetic dystrophy, the proposed surgery may make her significantly worse. Based on the information reviewed, there is nothing to support the need for the proposed surgery and the potential disadvantages far outweigh the potential advantages of any planned surgery.

## Screening Criteria

### 1. Specific:

- ACOEM Guidelines do not apply.
- Orthopedic Sports Medicine. Principle and Practice DeLee & Drez second Edition. Chapter 9 p. 441- 457
- Official Disability Guidelines Fourth Edition Treatment in Worker's Compensation 2006 p. 661

### 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 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 Resolution Officer**

Cc:               SORM                               Jack McCarty  
                    Attn: Jennifer Dawson       Fax: 806-791-0454  
                    Fax: 512-370-9170

## **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 Patient's representative) and the DWC via facsimile, U.S. Postal Service or both on this 1<sup>st</sup> day of June, 2006..**

**Name and Signature of IRO America Representative:**

Sincerely,  
**IRO America Inc.**

Dr. Roger Glenn Brown  
**President & Chief Resolution Officer**