

August 10, 2006

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VIA FACSIMILE
TML Intergovernmental/FOL
Attention:Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-06-1488-01
DWC #: _____
Injured Employee: _____
Requestor: _____
Respondent: TML Intergovernmental/FOL
MAXIMUS Case #: TW06-0107

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308, which allows for a dispute resolution by an IRO.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician who is board certified in orthopedic surgery on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider 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 carrier health care providers who reviewed the case for decision before referral to the IRO, was signed. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns an adult male who had a work related injury on _____. Records report that while jumping he sustained a twist injury to the right knee. Diagnoses have included large chondral defect, partial lateral meniscal deficiency, and prior partial lateral meniscectomy (2004). Evaluation and treatment have included surgery, medications, physical therapy and bracing.

Requested Services

Preauthorization for right knee chondrocyte.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter of Appeal – 6/30/06
2. Correspondence and records from Wayne K. Gersoff, MD –3/13/06-5/10/06
3. Correspondence and records from David R. Schmidt, MD – 10/27/05-4/7/06
4. Preauthorization for Surgery – 4/12/06
5. Operative Report – 10/1/04
6. Progress Notes 9/16/04-10/28/04

Documents Submitted by Respondent:

1. Carrier's Position Statement – 6/21/06
2. Review Determination – 4/10/06, 4/19/06, 4/20/06

Decision

The Carrier's denial of authorization for the requested services is upheld.

Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

Rationale/Basis for Decision

The MAXIMUS physician consultant indicated that chondrocyte transplantation is experimental for treatment of knee osteochondral defects. The MAXIMUS physician consultant noted there are no long term outcome studies demonstrating the procedure's efficacy at this time. The MAXIMUS physician consultant explained that more outcome data is necessary to support this procedure as a standard of care for treatment of the member's condition. (Wood JJ, et al. Autologous cultured chondrocytes: adverse events reported to the United States Food and Drug Administration. J Bone Joint Surg Am, 2006 Mar; 88(3): 503-7.)

Therefore, the MAXIMUS physician consultant concluded that the requested preauthorization for right knee chondrocyte is not medically necessary for treatment of the patient's condition.

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.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department

cc: Division of Workers Compensation

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 10th day of August 2006.

Signature of IRO Employee: _____
External Appeals Department