

NOTICE OF INDEPENDENT REVIEW DECISION

February 3, 2006

Requestor

Frank Weedon  
P.O. Box 3959  
Longview, TX 75606

Respondent

Hartford Insurance Co. of the Midwest  
ATTN: Barbara Sachse  
Fax#: (512) 343-6836

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M2-06-0391-01  
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC 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 1962, 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 the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on \_\_\_ when he injured his right knee when he fell at a \_\_\_\_\_, hitting directly on the right knee. An MRI of the right knee revealed that the patient is suffering from severe patellofemoral chondromalacia, mild to moderate chondromalacia involving the medial joint space, and early lateral joint line osteophyte formation. The treating physician has recommended that the patient undergo a right knee arthroscopy.

Requested Service(s)

Right knee arthroscopy

Decision

It is determined that a right knee arthroscopy is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has an arthritic knee that was relatively silent until the injury on \_\_\_ caused intractable pain to the knee. An arthroscopy is the first step to restoration of the knee and will give the physician information (photographs and operative report) that supports the diagnosis. The event (the on the job injury) started the patient's symptoms and an arthroscopy is an appropriate treatment.

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

**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.

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 Department of Insurance, Division of Workers' Compensation, 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: Injured Worker  
Program Administrator, Medical Review Division, DWC

In accordance with Division 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 3rd day of February 2006.

Signature of IRO Employee:

Printed Name of IRO Employee: