

Notice of Independent Review Decision

DATE OF REVIEW: 12/27/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient three days right knee, right total knee arthroplasty at xxxxxxx

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The XXXXX physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the Inpatient three days right knee, right total knee arthroplasty is not medically necessary to treat this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was working and injured his right knee. This resulted in pain, swelling and buckling of the right knee. He has been treated with analgesics, physical therapy, injections to the right knee and

surgery. The treating physician is recommending a right total arthroplasty with a 3 day stay.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The extent to which this patient has been provided with standard non operative treatment has not been well documented. xxxx-supplementation has not been documented. The patient is younger than the acceptable age recommended in the ODG, 2012. Prior denials of this surgical preauthorization request have been based on the failure to adequately meet and satisfy criteria of conservative care and age. The prior denials were appropriate and should be upheld. Medical necessity criteria have not been satisfied appropriately. Medical necessity for total knee arthroplasty and three day stay has not been established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)