

Applied Assessments LLC

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 03/02/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Right total knee replacement inpatient surgery

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)

Patient Clinical History (Summary)

The patient is a male. On XX/XX/XX, the patient was taken to surgery for right partial medial meniscectomy, and ablation arthroplasty medial femoral compartment. On XX/XX/XX, patient was taken back to surgery for retain posterior horn meniscus and diagnostic arthroscopy and partial meniscectomy was performed. On XX/XX/XX, patient was taken back to surgery for a partial median medial meniscectomy, and arthroscopic debridement. On XX/XX/XX, the patient turned to clinic. Again reported knee pain rated at 9/10. On exam, he had normal reflexes. A total knee replacement was recommended.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The XX/XX/XX utilization review report was submitted indicating there was insufficient evidence to support the need for a total knee replacement as there was nothing in the progress notes presented for review indicating any treatment other than multiple knee arthroscopies had been performed. On XX/XX/XX, utilization review report stated the requested total knee replacement was not medically necessary as imaging studies and objective and subjective findings were lacking substantial information that was critical in authorization the request as there was no recent weight bearing x-ray report showing in significant joint disease in two or more compartments. The request was non-certified.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)