Applied Assessments LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 6/7/2019 3:45:44 PM CST

Applied Assessments LLC

An Independent Review Organization
900 Walnut Creek Ste. 100 #277
Mansfield, TX 76063
Phone: (512) 333-2366
Fax: (888) 402-4676
Email: admin@appliedassessmentstx.com

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1.X.

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

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☒ Partially Overturned	Agree in part/Disagree in part
☐ Upheld	Agree

1X

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
- Physician Work Activity Status Reports –X
- Physician Advisor Reports –X
- Diagnostic Data Reports –X

Applied Assessments LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 6/7/2019 3:45:44 PM CST

PATIENT CLINICAL HISTORY [SUMMARY]: X. X is a X year-old X who was injured on X. X sustained a work-related injury while working for X as a X. X had a X as X went into an X. X was diagnosed with X with areas of X,X.X, MD evaluated X. X on X for re-evaluation with respect to a work-related injury sustained while working for X as a X on X. X continued to have persistent pain in the X . Examination findings included X, X, and X. X was also noted. The assessment was complex X with areas of X. Per Dr. X, X. X was not a candidate to perform X procedure or X. The plan was also to undergo X. X. X could continue to X. Per an initial X consultation visit note dated X by Dr. X X. X was seen for X pain in the X. X. X sustained a X as X went into an X. Examination of the X revealed X over the X with X pain with X. The assessment was X with possible X, X as well as X. The plan was to X. X. X was monitored on X with X. X-rays of the X done on X demonstrated normal findings. MRI of the X performed on X showed X and X involving the X of the X with high-grade central and posterior medial compartment XX and mild XX stress reaction involving the XX aspect of the X and X. It also demonstrated high-grade X involving the X of the X with X reaction. There was also XX effusion. It also showed X involving the X of the X, probably representing X. Treatment to date included a short course of X, over-the-counter X Per an adverse determination letter dated X by X , MD, the request for surgical X of the X with X and X of the X was non-certified. It was determined that the recent MRI of the X did not show an evidence of a X. The examination of X. X showed X, X, X. The X was limited in all X. Although the X portion of the requested procedure was supported, as noted in the prior determination, the request for X could not be supported given that X age was over X years with no evidence of XX. As a portion of the requested procedure was found not medically necessary, the request in its entirety was not supported. An adverse determination letter dated X by X, MD indicated that the request regarding the surgical intervention of X portion might be supported. However, there was no new information to support the requested X, as X. X was greater than X years of age with no evidence of a X as per the MRI findings. The request for X, X was non-certified.

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

The ODG recommends X when there are at least two pertinent subjective complaints, at least two pertinent objective findings, MRI findings of a, and a failure of X treatment including X in addition to activity X. The ODG recommends X in patients age X or younger who have a small to X defect on the X portion of the X. The provided documentation indicates this X year-old has persistent X pain despite treatment with X, the use of a X. There is also documented subjective X. Physical examination findings include in X and X. An MRI of the X showed a X. While the MRI reveals X, there is no evidence of a X. Based on the provided documentation and ODG recommendations, the X with X is medically necessary, but the X is not medically necessary.

Recommendation is for partially X the previous denials. The X with X is overturned as these are supported as medically necessary. The X as medical necessity 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

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

Applied Assessments LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 6/7/2019 3:45:44 PM CST

☐ 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 & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

ODG, 2019: XX and XX; XX or XX repair