



Notice of Independent Review Decision

---

**IRO REPORT**

---

**DATE OF REVIEW: 10/11/07**

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Determine the medical appropriateness of the previously denied request for continued inpatient stay after 8/10/07.

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

Texas Licensed Orthopedic Surgery M.D.

**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)

The previously denied request for continued inpatient stay after 8/10/07.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Fax Cover Sheet dated 9/11/07, 9/5/07, 8/30/07, 8/15/07, 8/9/07.
- Letter dated 9/11/07.

- **Notice to CompPartners, INC. of Case Assignment dated 9/25/07.**
- **Request from a Utilization Review Agent for Assignment of an Independent Review Organization dated 8/30/07.**
- **Request Letter dated 8/30/07.**
- **Appeal Letter dated 8/16/07.**
- **Request for a Review by an Independent Review Organization dated 8/14/07.**
- **Determination Letter dated 8/9/07.**
- **Pulmonary Critical Care and Sleep Disorders dated 8/9/07.**
- **Progress Notes dated 8/8/07, 8/6/07.**
- **PM and R Note dated 8/8/07.**
- **Lab Report dated 8/5/07.**
- **Face Sheet dated 7/30/07.**
- **History and Physical dated 7/28/07.**
- **Notes dated 7/27/07.**
- **Request Form dated (unspecified).**
- **Prescription dated (unspecified).**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:**

**Gender:** Male

**Date of Injury:**

**Mechanism of Injury:** Suicide attempt by hanging.

**Diagnosis:**

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

This male was injured in a suicide attempt by hanging, with resultant anoxic brain injury and respiratory failure. The patient developed pneumonia and sepsis. After being treated acutely on an inpatient basis with a ventilator and subsequent sepsis, the patient was subsequently transferred to Hospital, on 7/28/07, for long-term ventilator management. On admission to Hospital, the patient was noted to be awake with flailing motions of the arms and legs and intermittently looking around. The patient, however, did not respond to any kind of verbal stimuli and only painful tactile stimuli. The majority of the handwritten progress notes from Hospital were illegible or of poor fax quality for coherent information. On 8/6/07, the patient was de-cannulated, and the neurology evaluation on that date indicated that the patient was doing very well. The 8/8/07 physical therapy/occupational therapy note indicated tilt table treatment with edge of bed sitting and what appears to say "ataxic in all movements." Speech therapy indicated no attempts to breathe words and follows commands inconsistently. The Nurse U.M. indicates on 8/15/07 Dr. stated the patient was attempting to talk and seemed to recognize his family. There was a note of unknown date, with the signature by the physician being illegible, which indicated that the patient has made slow, but steady neurologic improvements and rehabilitative gains. The rest of the information was handwritten and difficult to decipher. The recommendation is to uphold the prior denial for acute inpatient stay after 8/10/07, as

the medical records indicated that the patient was stable enough to transfer to a rehab setting. The medical records indicated, as of that date, that the patient was receiving rehab care at the Hospital and did not contain information indicating acute care was being provided. This adverse determination is relying on the prior denial according to plan benefits. The benefit certificate was not available for review.

**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 CHRIOPRACTIC QUALITY ASSURANCE AND 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).

- plan benefits

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.**

---