



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 04/07/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Hospital bed and fracture frame bar (E0265 and E1399)

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

Board Certified in Physical Medicine & Rehabilitation

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.

Hospital bed and fracture frame bar (E0265 and E1399) – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An IVP with tomograms interpreted by, M.D. dated 03/24/05

X-rays of the right knee interpreted by Dr. dated 04/15/05
Evaluations with, M.D. dated 07/25/05, 10/03/05, and 05/01/06
Laboratory studies dated 08/16/05
An EMG/NCV study interpreted by, M.D. dated 10/10/05
MRIs of the cervical spine and brachial plexus interpreted by, M.D. dated 10/21/05
Evaluations with, M.D. dated 10/31/05, 11/16/05, and 02/22/06
A procedure note from Dr. dated 12/30/05
An admission record from, M.D. dated 01/03/06
A CT scan of the head interpreted by, M.D. dated 01/03/06
MRIs of the brain and lumbar spine interpreted by, M.D. dated 01/03/06
An evaluation with, M.D. dated 08/09/06
An evaluation with, D.C. dated 11/28/06
Evaluations with, M.D. dated 12/07/06, 01/18/07, and 04/10/07
An evaluation with Dr. (no credentials were listed) dated 01/10/07
A home health certification and plan of care form from, R.N. dated 11/28/07
An evaluation with, M.D. dated 01/08/08
A preauthorization request form from Dr. dated 01/15/08
A letter of adverse determination, according to the ODG, from, M.D. dated 02/08/08
A letter from Dr. dated 02/18/08
A letter of reconsideration request from Dr. dated 02/20/08
A letter of adverse determination, according to the ODG, from, M.D. dated 02/20/08
An undated list of previous surgeries and injuries
An undated equipment pricing and coding worksheet
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An IVP with tomograms interpreted by Dr. on 03/24/05 revealed spina bifida occulta at S1, postsurgical changes in the perineum/scrotal region, and phleboliths in the left pelvis. X-rays of the right knee interpreted by Dr. on 04/15/05 were unremarkable. On 07/25/05, Dr. recommended the Arthritis Foundation pool program, laboratory studies, and Clonazepam. An EMG/NCV study interpreted by Dr. on 10/10/05 was essentially unremarkable. MRIs of the cervical spine and brachial plexus interpreted by Dr. on 10/21/05 revealed degenerative changes at C2 through C5. On 10/31/05, Dr. recommended Lyrica, a psychological evaluation, and possible pain pump placement. On 12/30/05, Dr. performed an intrathecal trial. A CT scan of the head interpreted by Dr. on 01/03/06 revealed inferior frontal lobe low densities. An MRI of the brain interpreted by Dr. on 01/03/06 revealed a focal area of encephalomalacia in the left frontal lobe that was described on a CT scan in 1997, and wallerian degeneration. An MRI of the lumbar spine interpreted by Dr. on 01/03/06 revealed mild degenerative changes at L4-L5 and L5-S1. On 05/01/06, Dr. recommended individual psychotherapy, a

Required Medical Evaluation (RME), maintenance medications, a health club membership, bathroom modifications, and wheelchair gloves. On 11/28/06, Dr. recommended an evaluation with Dr., physical therapy, a home care aid, and a possible social worker. On 12/07/06, Dr. increased Clonazepam, continued Amitriptyline, and prescribed Remeron. On 01/18/07, Dr. decreased Xanax, discontinued Methadone, and prescribed Marinol. On 11/28/07, Ms. recommended bed equipment and a hospital bed with a trapeze. On 02/08/08, Dr. wrote a letter of adverse determination for the hospital bed and fracture frame bar. On 02/18/08, Dr. wrote a letter of medical necessity for the bed and fracture frame. On 02/20/08, Dr. wrote a letter of adverse determination for the bed and fracture frame.

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

Based upon the medical records available for review, it appears the patient initially had a fibular fracture to his leg. He subsequently underwent multiple surgical procedures to that leg, including removal of hardware. During the treatment of his fracture in the right ankle, he developed posttraumatic complex regional pain syndrome, Type I. This has caused a chronic pain pattern in this individual. In the letter dated 02/18/08 from Dr., he writes that the hospital bed and fracture frame are a medical necessity for this patient. However, he does not provide a physical examination to confirm this patient's current disability or impairment in mobility to require these pieces of equipment. The patient was using a wheelchair for mobility in the available records, but it does not state that he had any difficulty with wounds on the lower extremities which would require a hospital bed and no fractures have been identified. The patient's upper extremities, based on the medical records, appear to be functioning well. He should be able to get out of a standard bed without the assistance of a fracture frame or the manipulation of the bed to raise his head. Therefore, the requested hospital bed and fracture frame bar (E0265 and E1399) are not reasonable or necessary.

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 AND KNOWLEDGE BASE**
- 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)