

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 09/08/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Home care services from 03/10/08 through 07/27/08

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

The TMF 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice of Independent Review from – 02/13/08
- Decision letter from – 05/10/06, 08/01/07
- Decision letter from Medical Review – 02/29/08
- Office visit notes by Dr. – 02/16/06 to 07/17/08
- Office visit notes by Dr. – 01/31/08
- Office visit notes by Dr. – 09/11/03 to 02/27/08
- Office visit notes by Dr. – 04/01/08 to 05/27/08

- Office visit notes by Dr. – 11/21/07
- Office visit notes by Dr. – 08/09/06
- Report of x-ray of the – 05/12/08
- Prescription for morphine – 06/10/08
- Home health notes for infusion pump – 06/10/08
- MSW assessment – 11/08/07
- Speech Therapy/Occupation Therapy evaluation and treatment plan – 11/08/07
- Report of x-ray of the right knee – 10/02/07
- Report of x-ray of the chest – 09/27/07, 09/29/07
- Prescription for skilled nursing and social worker evaluation – 10/31/07
- Discharge Summary from – 09/26/07 to 10/02/07
- Request for skilled nursing visits from – 11/05/07
- Emergency Department record – 09/27/07
- Skilled Nursing Visit Notes – 11/09/07 to 11/12/07
- Prescription for motorized wheel chair and lift – 04/12/06
- Medical record review by Dr. – 01/17/06
- Neurological history by Dr. – 05/18/06
- Orthopedic examination and evaluation by Dr. – 03/04/05
- Decision letter from – 04/24/06, 05/10/06
- Letter from to – 05/15/06, 06/16/06
- Letter from to – 05/25/06, 07/27/07, 09/20/07, 08/05/08, 08/18/08
- Letter of medical treatment from Dr. – 05/02/06
- Letter to from Office of – 06/15/06
- Decision letter from – 04/24/06, 05/03/06, 05/10/06, 08/31/06, 09/07/06, 08/02/07, 09/28/07
- Letter from and to – 06/30/06, 09/18/06
- Invoice for in-home services – 05/02/06 to 05/31/06, 06/01/06 to 06/15/06, 06/16/06 to 06/30/06, 07/01/06 to 07/15/06, 07/16/06 to 07/31/06, 08/01/06 to 08/15/06, 08/16/06 to 08/31/06, 09/01/06 to 09/15/06, 10/01/06 to 10/31/06, 11/01/06 to 11/30/06, 12/01/06 to 12/31/06, 01/01/07 to 01/31/07, 02/01/07 to 02/28/07, 03/01/07 to 03/31/07, 04/01/07 to 04/30/07, 05/01/07 to 05/31/07, 06/01/07 to 06/30/07, 07/01/07 to 07/31/07, 08/01/07, 08/02/07 to 08/05/07, 08/06/07 to 08/12/07, 08/13/07 to 08/19/07, 08/20/07 to 08/26/07, 08/27/07 to 09/02/07, 09/10/07 to 09/16/07, 09/17/07 to 09/23/07, 09/24/07 to 09/30/07, 10/01/07 to 10/07/07, 10/08/07 to 10/14/07
- Letter to from – 06/21/06, 07/06/06, 09/14/06, 08/18/08
- Peer review analysis from mcmc – 04/24/06
- Prescription for Live-in care giver – 06/19/07
- Letter of History of Present Illness by Dr. (barely legible) - ?
- Functional Capacity Evaluation – 08/30/04
- Report of EMG/Nerve Conduction Study – 09/08/06
- Phone record notes - 05/20/06 to 06/22/06

- Letter from the live-in caregiver – 05/30/06
- Letter from to Dr. – 03/05/07
- Letter from Dr. – 08/28/07
- Operative report for EGD with biopsy – 09/26/07
- History and Physical by Dr. – 09/26/07
- Laboratory values – 09/27/07 to 10/02/07
- Report of MRI of the lumbar/thoracic spine – 09/29/07
- Report of gastric antrum biopsies – 09/30/07
- Report of x-rays of the thoracic spine – 05/10/07, 08/23/07, 09/13/07
- Report of MRI of the thoracic spine – 06/26/07, 09/13/07
- Operative report for vertebroplasty and epidural steroid injections – 08/22/07
- Report of x-rays of the cervical spine – 03/06/07
- Report of x-rays of the lumbar spine 03/06/07, 09/13/07
- Medical Fee Dispute Resolution Request/Response – no date
- Table of disputed services – 08/15/06 to 08/01/07
- Designated Doctor Evaluation – 10/05/07
- Confirmation of Receipt of a Request for a Review by an IRO – 08/28/08
- Information for requesting a review by an IRO – 08/23/08
- Request for Payment of Services 04/24/08 to 07/28/08
- Copies of checks – 03/19/08 to 07/23/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was lifting a ladder and fell with the ladder causing pain and injury to his lower spine. The patient has been treated conservatively with physical therapy, massage therapy, TENS unit, ultrasound, work hardening and injections. The medical record documentation indicates that the patient suffers from multiple failed back surgeries, chronic pain syndrome, osteoporosis, failed back with subsequent multiple compression fractures. The documentation indicates that the patient has had a live-in care giver from at least May of 2006.

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

The medical record documentation indicates that the patient is totally and permanently disabled. His back pain, his pain medication, his compression fracture history, his osteoporosis, etc. have produced an individual who is marginally functional even while utilizing a motorized wheelchair. This patient requires the services of a 24 hour care giver or a skilled nursing facility level of care. The services of a 24 hour care giver have been provided according to precedent and should be compensated for.

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)