

True Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/06/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Levator Repair with Bledpharoplasty and Direct Browlift of the Left Upper Lid

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

Board certified fellowship trained Ophthalmologist in private practice for 27 years.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

33 pages from (not all pages dated but range noted between (9/21/07-6/5/09)

17 pages from UR Unit dated 9/16/09

Denial Letters 8/6/09 and 7/9/09

PATIENT CLINICAL HISTORY SUMMARY

Pt sustained a traumatic injury to his left eye requiring vitrectomy and lensectomy.

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

PATIENT NOTED TO HAVE PTOSIS OF HIS LEFT UPPER EYELID AFTER TRAUMATIC INJURY--AS IS CLEAR FROM THE PHOTOS PROVIDED. HOWEVER, HE HAS NO SPECIFIC COMPLAINTS REGARDING LIMITATION IN HIS SUPERIOR VISUAL FIELD FROM THE LEFT EYE. ADDITIONALLY, HIS GOLDMAN VISUAL FIELD SHOWED ONLY MINIMAL IMPROVEMENT WHEN THE LID WAS MECHANICALLY ELEVATED ("LID TAPED")--THUS INDICATING THAT THE DECREASE IN OVERALL VISUAL FIELD IN THE LEFT EYE WAS LIKELY DUE TO PROBLEMS OTHER THAN THE "DROOPY" EYELID.

THE MEDICAL NECESSITY FOR THE PROPOSED EYELID PROCEDURES WAS NOT ESTABLISHED.

Not Addressed in ODG

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)