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DATE OF REVIEW: December 13, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Skilled nursing/home health x 15 for wound VAC dressing changes.

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI:

- Utilization reviews (09/29/10 – 10/08/10)

- Office visits (09/24/10 – 09/28/10)
- Utilization reviews (09/29/10)

- Office visits (09/24/10 – 11/29/10)
- Utilization reviews (09/29/10)

- Office visits (11/12/09 - 10/21/10)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury to his lower back on xx/xx/xx. Exact mechanism of injury is not available.

On November 4, 2009, M.D., an orthopedic surgeon, performed revision lumbar surgery at L4-L5 and L5-S1 bilaterally; revision sacral spine surgery with 1st sacral interval bilaterally, removal of EBI transmitter unit, exploration of arthrodesis, and repair of pseudoarthrosis from L4-L5 bilaterally. The postoperative diagnosis was failed lumbar spine syndrome with retained symptomatic hardware.

On November 12, 2009, Dr. performed revision of lumbar spine surgery at L4-L5 bilaterally with exploration, irrigation and debridement and removal of necrotic tissue for infection with methicillin-resistant staphylococcus aureus (MRSA) and meningeal irritation. Postoperatively, Dr. treated the patient with intravenous (IV) antibiotics and wound dressings.

On December 15, 2009, Dr. noted the patient had stopped his IV antibiotics. His wound was now measuring approximately 7 cm in length and 5 cm in depth. Dr. scheduled him for outpatient surgery for delayed primary closure of the wound.

In January 2010, Dr. noted the patient had been evaluated in the emergency room (ER) for complaints of increasing back pain, non-healing wound, drainage and fever. X-rays showed no evidence of deep hardware involvement or bony involvement. He started the patient on IV antibiotics.

In March, Dr. noted the patient was off IV antibiotics for approximately a week and had another punctate lesion in his midline incision dehiscence with some drainage. The patient was treated with triple sulfa compound, hydrogen peroxide, Keflex and clindamycin. The patient was referred to infectious disease specialist.

D.C., noted localized pain with some discomfort and radiculopathy into the bilateral lower extremities. He diagnosed failed back syndrome status post battery removal and status post re-infections and referred the patient to Dr. for interventional pain management and medication management and ordered physical therapy (PT).

In September, the patient was admitted to Hospital for complaints of recurrent infection, fever, swelling, chills and oozing of fluid from the surgical site. Computerized tomography (CT) showed ill-defined fluid collection within the posterior surgical bed at L4-L5 with paraspinal soft tissue with a surgical drain passing through the fluid collection; and solid osseous fusion at L5-S1. The patient was started on potassium, magnesium replacement protocol, Tylenol, Norco and Dilaudid.

On September 20, 2010, Dr. performed revision lumbar spine surgery with incision and drainage at L4-L5 and L5-S1 bilaterally; revision sacral spine surgery with first sacral interval bilaterally; revision surgery at L2-L3 and L4-L5 bilaterally; exploration of arthrodesis and removal of post instrumentation segmental fixation from L2 through L5 bilaterally with crosslinks at L2-L3 and L4-L5. During the hospital stay, the patient was treated with IV Rocephin, Ancef and a PICC line was inserted for parenteral antibiotics. The patient underwent eight home health visits for wound VAC dressing changes.

On September 29, 2010, M.D., denied the request for home health x 15 (thrice a week) for wound VAC dressing changes based on the following rationale: *“A peer-to-peer contact was not established despite two phone calls on two separate days. The patient seems to have completed eight home health visits for wound VAC dressing changes. No recent clinical information is available. There is no documentation about the current wound status including the healing or any discharge. There is also no documentation about the domestic situation of the*

patient, i.e., if he has a family member or spouse who can change his dressing. It is also unclear if the patient is home bound at this time to justify the continued home health visit. Additional clarification is needed to justify the 15 home health visits”.

From October 2, 2010, through November 29, 2010, the patient underwent 23 home health visits for wound VAC dressing changes.

On October 8, 2010, M.D., denied the appeal for skilled nurse/home health x 45 days based on the following rationale: *“Basis for recommendation is that while the patient may need 45 days of home IV antibiotics which would be done typically by a nurse in a home health setting through the PICC line, it is not clear that 45 days of wound care would be needed and the notes that this reviewer had available were regarding wound VAC care. There is lacking evidence that this entire timeframe would be needed for wound VAC care and requesting provider listed, Dr., was deferring wound VAC care to ortho. Wound could heal prior to 45 days.”*

On October 20, 2010, Dr. noted the patient continued to have an infectious wound tube and filtration unit surgically implanted into the soft tissue of the lumbar spine.

On October 21, 2010, M.D., a pain management specialist, noted a pain score of 10/10. The patient complained of aching and burning pain in the lower back. History was significant for 10 back surgeries, hypertension and anxiety. Dr. diagnosed chronic pain syndrome, low back pain, failed back surgery syndrome and recurrent infections. He treated the patient with Opana, Soma, Neurontin and hydrocodone. He noted the patient would receive two more weeks of IV antibiotics and then the PICC line would be removed.

On November 29, 2010, per skilled nursing report, the wound VAC was not applied in order to allow the physician to observe the wound. The patient was encouraged to keep the dressing dry and intact to avoid infections.

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

Based on the records and history clearly IV antibiotics are reasonable and if the request is for simply changing the dressing on wound vac times fifteen given the history the request is reasonable. Therefore, it is my opinion the request for fifteen changes total with a frequency of three times per week is reasonable.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS