

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 01/04/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Home health nursing visits daily for two weeks (total of 14 visits).

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 in internal medicine 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.

It is determined that the home health nursing visits daily for two weeks (total of 14 visits) are medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 12/11/09
- Letter of determination from – 11/11/09, 12/02/09

- Determination of pre-authorization review by Reviews – 11/11/09
- Determination of appeal review by Reviews – 12/02/09
- Letter from – 12/10/09
- Preauthorization request for home nursing – No date
- Portion of patient hospital record from Medical Center for admission date of 11-01-09
- Copy of Doctor's Orders for home health care – 11/06/09
- Texas Division List Patient Notes – 11/02/09, 11/06/09
- Operative Report for and debridement of wound – 11-04-09
- Discharge Summary from 11-01-09 admission – 11/06/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he stepped on a water meter cover which flipped over causing an avulsion and laceration wound on the anterior lateral aspect of his mid left leg. The patient was admitted to the hospital and underwent an incision and drainage with debridement of a chronic wound of the left leg. Following discharge from the hospital, home health services were arranged to do dressing changes daily for two weeks.

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

The surgical report describes severe damage to the patient's leg. The wound cavity extended several centimeters inferiorly and laterally from the area of the opening. Extensive packing with Iodoform gauze was done at the time surgery. Standard wound care required removal of the packing and then re-packing twice a day initially and then daily. It is unreasonable to expect a patient to ambulate twice daily to a hospital or clinic for debridement and changing of packing which is a home health duty and allows the patient to be home and not in the hospital.

**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)