

Notice of Independent Review Decision  
**IRO REVIEWER REPORT**

DATE OF REVIEW: 10/06/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Urgent Skilled Nursing Services 1xWk x 1Wks RN Eval

Urgent Skilled Nursing Services 7xWk x 4 Wks wound care to include LPN

Urgent Physical Therapy 3x Wk x 4Wks-RLE

Urgent Occupational Therapy 3x Wk x 4Wks-RLE

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

The TMF physician reviewer is board certified in physical medicine and rehabilitation 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:

Urgent Skilled Nursing Services 1xWk x 1Wks RN Eval; Urgent Skilled Nursing Services 7xWk x 4 Wks wound care to include LPN; Urgent Physical Therapy 3x Wk x 4Wks-RLE; Urgent Occupational Therapy 3x Wk x 4Wks-RLE are all medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/21/10
- Notice of determination from – 09/03/10, 09/15/10
- Progress notes by Dr.– 09/08/10
- Rehabilitation discharge summary by Dr. for discharge of – 09/01/10
- Results of x-rays of the right knee – 08/06/10, 08/08/10, 08/19/10
- Results of x-rays of the right shoulder – 08/05/10, 08/06/10, 08/18/10
- Results of x-rays of the right tibia and fibula – 08/05/10, 08/18/10
- Results of chest x-ray – 08/11/10
- Results of CT angiography abdominal aorta plus bilateral iliofemoral – 08/09/10
- Results of x-rays of the right humerus – 08/05/10
- PM & R History and Physical by Dr.– 07/14/10
- Request for post discharge services by Dr.– 09/01/10
- Progress notes from Health Services Inc – 09/04/10
- Health Service Inc, verbal orders from Dr.– 09/02/10, 09/04/10
- Home health aide care plan assignment sheet from Home Health Services Inc – 09/02/10

- Admission case conference from Health Services Inc – 09/02/10
- Rehabilitation flow sheet – 07/14/10 to 08/01/10

**PATIENT CLINICAL HISTORY (SUMMARY):**

This patient was involved in a motor vehicle accident when his truck rolled over. He sustained a mild traumatic brain injury, and multiple other injuries including a forehead laceration, right thumb laceration, large right leg laceration, left dorsal hand laceration to 2<sup>nd</sup> – 5<sup>th</sup> fingers with exposed tendon at 3<sup>rd</sup> knuckle, nasal fracture, right open tibia fibula fracture and fracture of the right humeral head. He underwent multiple surgical repairs and fixations and then physical rehabilitation. Upon discharge, the physician ordered home health care to include:  
 Urgent Skilled Nursing Services 1xWk x 1Wks RN Eval  
 Urgent Skilled Nursing Services 7xWk x 4 Wks wound care to include LPN  
 Urgent Physical Therapy 3x Wk x 4Wks-RLE  
 Urgent Occupational Therapy 3x Wk x 4Wks-RLE

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

This patient was involved in an truck rollover causing multiple traumatic injuries with surgery and aftercare that was followed by inpatient rehabilitation. The patient was discharged home on 09/01/10 with continued wound care to the right leg with pseudomonas and enterococcus colonization of an open wound with exposed bone. The patient’s treatment required daily nursing visits initially for this serious wound. This injury, in addition to upper extremity injuries, requires further rehabilitation. The patient’s discharge functional status is moderate assistance with lower extremity dressing, minimal assistance with transfers, toileting and bathing. Therefore, it is determined that the above listed services are medically necessary to treat this patient’s condition.

**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)