

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Retrospective Inpatient Stay 99356 from 12/13/10 to 12/22/10
Retrospective surgery left femur fracture 27365

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

M.D. Board Certified Orthopedic Surgeon

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)

The reviewer finds that retrospective Inpatient Stay 99356 from 12/13/10 to 12/20/10 is medically necessary.

The reviewer finds that retrospective Inpatient Stay 99356 from 12/21/10 to 12/22/10 is not medically necessary.

The reviewer finds that retrospective surgery left femur fracture 27365 is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer Reviews 02/07/11, 02/15/11
Official Disability Guidelines Treatment in Worker's Comp
X-ray left hip/pelvis 12/12/10
X-ray left foot 12/22/10
E- records: resident assessment and care screening/resident admission record/consent for medication record 12/13/10
Nursing records 12/13/10, 12/15/10, 12/20/10,
History and physical 12/14/10
Physician orders 12/14/10, 12/16/10, 12/18/10, 12/20/10, 12/21/10, 12/22/10,
Occupational therapy records 12/14/10 to 12/20/10
Resident assessment and care screening / nursing home discharge form 12/22/10
Resident transfer form 12/22/10
Nursing Care Plan, undated
Laboratory studies 12/21/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female who reportedly sustained a fall on XX/XX/XX, which resulted in a proximal femur fracture and subsequent open reduction and internal fixation. The records indicated that the claimant was admitted to a rehabilitation facility on 12/13/10 and discharged on 12/22/10. The records supported the claimant with co-morbidities of morbid obesity, hypertension and diabetes. The claimant was noted to be on multiple medications.

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

The patient is a XX-year-old woman who had a left hip subtrochanteric fracture. She underwent a subsequent open reduction internal fixation without apparent postoperative complication. Based on the records submitted, the reviewer finds that retrospective surgery left femur fracture 27365 is medically necessary.

The patient was discharged to a rehabilitation facility on 12/13/10 where she stayed through 12/22/10. The medical records provided document the fact that in the beginning she had difficulty ambulating. As the days went by, her ambulation improved. There is no documentation of progressive neurologic deficit, infection, lower extremity swelling, or other issue. There are five occupational therapy reports, 12/14/10 through 12/20/10 indicating improvement in dressing. There are no progressive physical therapy records documenting increasing function. Milliman Care Guidelines document the use of inpatient rehabilitation in patients who have the absence of acute hospital care needs and the intensity, and complexity of needs makes inpatient care a more efficient option. Plus, there should be necessary services of technical and professional personnel such as a nurse or a physical therapist. Therapy should provide ongoing assessment of rehabilitation needs and potential gait training and strengthening as well as supervision. Usually, that can be obtained within five to seven days following this type of surgery. It would appear from these medical records that the surgery and the first seven days of treatment from 12/13/10 through 12/20/10 would have been medically necessary, as per Milliman Care guidelines, but the last two days would not be medically necessary since there are no progressive therapy records documenting improvement over time. Therefore, up through 12/20/10, the inpatient care would have been medically necessary, but the last 2 days show no documentation of ongoing need for treatment in the inpatient stay. The reviewer finds that retrospective Inpatient Stay 99356 from 12/13/10 to 12/20/10 is medically necessary. The reviewer finds that retrospective Inpatient Stay 99356 from 12/21/10 to 12/22/10 is not medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates: Hip and Pelvis: Open reduction

Milliman Care Guidelines® Inpatient and Surgical Care 14th Edition: Surgical Admission Recovery Facility Care:

Clinical Indications for Admission to Recovery Facility

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