

Notice of Independent Review Decision

DATE OF REVIEW: 12/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Appeal split thickness skin graft 15100 11012 right foot/leg

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 hand surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice, is familiar with the treatment or proposed treatment and is the same specialty at the treating doctor.

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 appeal split thickness skin graft 15100 11012 right foot/leg is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 11/16/11
- Notification of Adverse Determination – 10/19/11
- Notification of Reconsideration Determination – 11/11/11
- Physician Statement from Dr. – 11/03/11
- Utilization Review Referral from Dr. – 08/17/11, 10/14/11
- Utilization Review Referral from Dr. – 10/14/11
- Orthopedics Progress Notes from – 07/11/11 to 10/07/11
- Ortho Trauma Progress Notes from Dr. – 07/07/11 to 10/06/11
- Report of MRI of the right foot – 09/28/11
- Report of x-rays of the right foot – 06/20/11, 10/06/11
- Operative report by Dr. – 08/23/11
- Orders for MRI of the right leg by Dr. – 09/12/11
- Physical Therapy notes – 09/06/11 to 09/08/11
- Portion of Out Patient Surgery Record – 08/11/11, 09/19/11
- Nursing Visit Notes – 11/08/11
- Wound Assessment Notes – 11/08/11 to 10/24/11
- Report of fluoroscopy for steroid injections – 06/28/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient suffered a work related injury on xx/xx/xx. It was a fork-lift injury that resulted in a crush fracture and dislocation of the right foot. This required surgery to include medical column plate and screws. He underwent a free flap to cover his wound and the flap has now atrophied and he is experiencing some swelling. There is a request for split thickness skin graft to the right foot.

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

This medical record documentation indicates that the second debulking procedure may be similar to the initial debulking, which was performed by tangential excision of skin and underlying muscle. Using this technique, a wound created with muscle bed which, with initial debulking, was allowed to heal with granulation or secondary intention because of concern for flap mobility. It appears that the surgeon intended to use the same technique for the second debulking, except that split thickness skin graft will be utilized to cover the open wound, which is entirely reasonable and appropriate if that is the judgment of the surgeon at the time of surgery versus allowing it to heal with granulation or by secondary intention.

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)**