

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
OP PARA PLANA VITRECTOMY WITH OZURDEX

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

MD, Board Certified Ophthalmologist
Fellowship trained, practicing vitreoretinal specialist

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Letters, 12/16/10, 12/22/10
12/30/10
MD, 12/16/10
Dr. 11/30/10, 9/28/10, 8/17/10, 7/27/10, 6/28/10, 6/1/10
Official Disability Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

THE PATIENT HAS A COMPLEX OCULAR HISTORY, INCLUDING UVEITIS, PRIOR CORNEAL TRANSPLANTATION AND EPIRETINAL MEMBRANE.

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

THE REQUESTING PHYSICIAN IS ASKING TO USE OZURDEX FOR UVEITIS. A PATIENT WITH UVEITIS WILL OFTEN HAVE SIGNIFICANT, VISION-AFFECTING INTRAOCULAR INFLAMMATION AFTER PARS PLANA VITRECTOMY WITH MEMBRANE PEELING FOR AN EPIRETINAL MEMBRANE. ADDING OZURDEX WOULD LIKELY DECREASE INFLAMMATION IN THE PERIOPERATIVE PERIOD AND COULD VERY

WELL BE QUITE USEFUL FOR THIS PATIENT. FOR THE DIAGNOSIS OF POSTERIOR UVEITIS, OZURDEX IS TYPICALLY GIVEN IN THE OFFICE. AS OF 9/27/2010, OZURDEX HAS FDA APPROVAL FOR USE IN POSTERIOR UVEITIS. THE REVIEWER FINDS THAT MEDICAL NECESSITY DOES EXIST FOR PARS PLANA VITRECTOMY WITH OZURDEX.

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)