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# Notice of Independent Review Decision

**DATE OF REVIEW:** 07/14/11

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Fourteen days in a skilled nursing facility

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Foot and Ankle Surgery

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

**X** 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.

Fourteen days in a skilled nursing facility - Upheld

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

## PATIENT CLINICAL HISTORY [SUMMARY]:

On 05/05/11, Dr. diagnosed the patient with calcaneal fractures and a tibial fracture and recommended an EKG, x-rays of the ankle and leg, CT scans of the lumbar and thoracic spine, Morphine, Zofran, Dilaudid, and Benadryl. On 05/05/11, Dr. recommended splinting and an external fixator on the left and a splint on the right. On 05/06/11, Dr. performed a left external fixation of the pilon and application of a right lower extremity short-leg splint. On 05/11/11, the patient was transported from to. On 05/13/11, Dr. wrote a letter of non-certification for 14 days in a skilled nursing facility. On 05/19/11, Ms. wrote a letter of reconsideration for the skilled nursing facility. On 05/20/11, the patient was transported by ambulance to. On 05/20/11, Dr. recommended Hydralazine, Vicodin, Mobic, Nexium, Lovenox, Ativan, and a Nicotine patch. On 05/24/11, Dr. performed left removal of external fixator, left ORIF of the pilon, and a left syndesmotic repair. On 05/27/11, the patient was back to for rehabilitation. On 06/06/11, Dr. also wrote a letter of non-certification for 14 days in a skilled nursing facility. Wound care was performed with Dr. on 06/09/11 and 06/16/11. On 06/16/11, the patient was also started on Cipro and was recommended for hyperbaric oxygen therapy.

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

Following his open reduction internal fixation on 05/24/11, the patient's external fixator was removed. I do not see a requirement for 24 hour care at a skilled nursing facility with the closed casting and otherwise, at this point, closed management and wound care for his calcaneal fracture. This patient has a strict requirement for non-weightbearing standards, but I do not believe that it meets the criteria guidelines for 24 hour care. He is not in need of any particular physical therapist to correct balance or strength, as he is not allowed weightbearing, and his upper extremities are not involved. There is no requirement for a speech therapist or any other occupational therapist to relearn independent self care, grooming, or eating. As stated, the only thing that really requires assistance which does not require professional assistance is transfers, which patient appears, as far as upper extremities go, intact to perform these on his own. He does require wound care as I have determined from the records, but this does not require 24 hour maintenance. There are no clinical findings in the record of chronic serious infection that requires administering and monitoring continuous or intermittent IV antibiotic administration. Therefore, the requested 14 days in a skilled nursing facility is neither reasonable nor necessary and the previous adverse determinations should be upheld.

## 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**
- [x] **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- [ ] **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)**