

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 31, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of the proposed gel or gel like pressure pad for mattress, standard mattress length and width (L0185)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.02	L0185		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Request for an IRO-17 pages

Respondent records- a total of 31 pages of records received to include but not limited to: Carrier letters 4.22.11, 4.27.11, 4.29.11, 5.11.11; TDI letter 5.11.11; request for an IRO forms; MRI report 4.22.11, 4.29.11; DME 4.7.11; script from Clinic 3.14.11; Physicians note 4.4.11; law firm letter 4.26.11

Requestor records- a total of 0 pages of records received to include but not limited to:
5.11.11-sent request for records to Dr.'s office
5.19.11- sent request for records to Dr.'s office

5.23.11- called and spoke to Dr.'s office manager regarding records, stated she would look into, no records sent

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of the April 22, 2011 non-certification of the above listed request. It was noted that the request was generated for the patient himself and that there was no clinical indication for these devices.

The non-certification determination was appealed. A reconsideration was completed and again the request was not certified. Again, there was no clinical rationale provided to support the request and there was no objectification that the claimant was unable to get out of bed unassisted.

The only clinical note presented is an April 4, 2011 progress note indicating the injury occurring X years prior, there was a distal upper extremity amputation, spinal fractures (now resolved) chronic pain and phantom limb pain. The patient complained of significant sleep problems. The diagnosis is a major depression, posttraumatic stress disorder and status post upper extremity amputation. Multiple medications were prescribed. There is no discussion or indication of the need for a gel pad over a mattress.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines "There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors." In short, the date of injury is years ago. There is no clinical data presented to support this request. This is a personal comfort device only. Thus, there is no competent, objective and confirmable medical evidence presented to support this request.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES