

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/06/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Hospital Bed

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

Board Certified PM&R and Pain 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Utilization review determination dated 07/02/12, 07/20/12
MRI lumbar spine dated 11/14/11
CT cervical spine dated 11/14/11
Office visit note dated 11/14/11, 12/01/11, 12/02/11, 12/13/11, 12/28/11, 12/29/11, 02/09/12, 04/05/12, 05/03/12
MRI left shoulder dated 02/28/12
Letter of medical necessity for hospital bed dated 01/10/12
Procedure report dated 11/14/11, 05/25/12
Radiographic report dated 11/17/11, 11/19/11, 11/20/11, 12/23/11
Letter dated 07/23/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell approximately 20-30 feet and sustained an L1 burst fracture, pelvic fracture and a left shoulder dislocation. The patient underwent closed reduction of left shoulder dislocation on xx.xx.xx followed by posterior lumbar decompression laminectomies fusion T11-L4 on 11/17/11. Note dated 12/02/11 indicates that the patient is able to ambulate without

assistance, but utilizes a wheelchair intermittently as he fatigues easily and it is uncomfortable to ambulate long distances. Letter of medical necessity dated 01/10/12 indicates that the patient has been recommended to be prescribed a hospital bed with full electrical capability due to the significant injuries that he is recovering from including the burst fracture he suffered in the lumbar spine including the disruption of bone and fragments in the spinal canal. Note dated 02/09/12 indicates that the patient has undergone ORIF of his pubic symphysis with closed reduction and percutaneous pinning of his right sacroiliac joint. The patient underwent left shoulder arthroscopic rotator cuff repair with extensive debridement and synovectomy on 05/25/12.

Initial request for hospital bed was non-certified on 07/02/12 noting that according to the records from the requesting provider, the patient is currently involved in the requesting provider's PT program which consists of 45 minutes of exercise per session. As the patient is capable of 45 minutes of exercise, the need for a special bed for home is not supported. The denial was upheld on appeal dated 07/20/12 noting that the documentation does not meet inclusion criteria for the request. The available documentation does not establish a condition for which an electrically manipulated hospital bed is reasonable or necessary. There is no indication that the patient requires special positioning or other conditions consistent with the recommendations from evidence based treatment guidelines.

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

Based on the clinical information provided, the request for hospital bed is not recommended as medically necessary, and the two previous denials are upheld. The Official Disability Guidelines do not specifically address hospital beds. Aetna Clinical Policy Bulletin for hospital beds notes that these beds are considered medically necessary DME for patients whose condition requires positioning of the body; conditions that require special attachments that cannot be fixed and used on an ordinary bed; or patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. The submitted records fail to establish that the patient meets any of the inclusion criteria. Also, the patient is currently involved in the requesting provider's PT program which consists of 45 minutes of exercise per session. As the patient is capable of 45 minutes of exercise, the need for a special bed for home is not supported.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

AETNA CLINICAL POLICY BULLETIN, HOSPITAL BEDS AND ACCESSORIES