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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/02/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: continued in-patient stay 4 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Internal 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. It is the opinion of the reviewer that the request for continued in-patient stay 4 weeks is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 06/25/13, 07/05/13
Letter dated 07/16/13
Lab report dated 06/21/13, 06/20/13
Utilization review medical necessity form dated 06/28/13
Appeal letter dated 07/09/13
History and physical dated 01/19/13
Medication list dated 06/21/13
Handwritten note dated 06/20/13
Vital signs dated 06/17/13-06/21/13
Patient care flow sheet dated 06/20/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient has a history of diabetes type 2 and had a left foot non-healing infection of the wound; the patient had amputation done about 2 years ago. He also has a history of hypertension. The patient is status post back surgery x 3, most recently approximately 9 years ago, then he had paraplegia with a neurogenic bladder developed. He has been residing at an assisted living facility for the last 8 years. He has been having chronic wound on and off during this period. The patient was admitted to the hospital in December 2012 due to an infected sacral decubitus ulcer. The patient was discharged to Plaza Specialty Hospital for wound care and IV therapy on 01/18/13 and has been inpatient at PSH since that time. The patient has been authorized for inpatient stay through 06/27/13. It is noted that a skilled nursing facility will not accept the patient.

Initial request for continued inpatient stay 4 weeks was non-certified on 06/25/13 noting that the claimant has had a very prolonged inpatient stay and documentation does not identify

significant information that warrants continued inpatient stay for 4 additional weeks. There is little evidence presented that the claimant would not be able to be managed with home health care at this stage. The denial was upheld on appeal dated 07/05/13 noting that the claimant has grade 3 decubitus ulcer and a complicated medical history. However, the claimant has already had prolonged hospitalization and there is limited information to justify further stay for four weeks. A clear explanation as to why the claimant is unable to receive continued antibiotic therapy and would care while in the assisted living facility is absent.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient was admitted on an inpatient basis in January 2013 and has been authorized for inpatient stay through 06/27/13. There is no clear rationale provided to support four additional weeks of inpatient stay when the patient's inpatient stay to date has been so extensive. There is no clear indication that the patient cannot be adequately treated with a lower level of care. As such, it is the opinion of the reviewer that the request for continued in-patient stay 4 weeks is not recommended as medically necessary.

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)