

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Feb/04/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Air ambulance transport xx/xx/xx

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

Neurology

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:

ODG - Official Disability Guidelines & Treatment Guidelines
Employer first report of injury or illness undated
Clinical records xx/xx/xx
Event chronology report from air ambulance crew xx/xx/xx
Clinical records xx/xx/xx -08/05/12
Peer review Dr. 09/10/12
Peer review addendum 10/25/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when he slipped and fell off of a truck. The patient was initially admitted to the emergency room at Medical Center in xx. The emergency room clinical report indicated that the patient arrived with complaints of pain in the head and face and neck and upper extremities. The patient arrived in cervical spine precautions with C-collar in place and the patient on a backboard. CT studies of the facial bones resulted in revealed ethmoid and orbital fracture. On initial exam, cranial nerves were intact and there were obvious bony deformities in the bilateral upper extremities as well as a 2x2cm evulsion above the right eye. GCS score was 15 at the time of admission. The patient was recommended to be transferred to the in xx. The patient was transferred by air. At the time of transfer, vital signs were temperature 98.9 and pulse 68 and regular respirations 18 and unlabored and blood pressure 140/60 with 100% O2 saturation on room air. The patient was received at the in on xx/xx/xx. No surgical procedures were recommended during admission and the patient was discharged with a right orbit fracture and a closed comminuted fracture of the left distal radius and a right forehead laceration with a right radial head fracture on 08/05/12. A peer review on 09/10/12 by Dr. indicated that there

was no valid medical indication for air transport in the case as there was no immediate decision for neurosurgical intervention and the patient had stable vital signs as well as neurocognitive function. An addendum from Dr. dated 10/25/12 indicated that there was no new information provided that would support the air ambulance transport.

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

Based on the clinical documentation provided for review, there is insufficient evidence to support the air ambulance transport from Medical Center to SU Health Science Center in. Upon admission to the emergency room at Medical Center, the patient was conscious and neurologically intact. GCS score was 15. Vital signs were also stable upon delivery to the air transport crew. In monitoring and review of the event chronology during air transport, there was no significant change in vital signs. There was also no indication per the clinical notes that any decision for emergency neuro surgical intervention was made that would have reasonably required an air transport of the patient. Based on the clinical documentation provided for review, there are clear indications that ground transport of the patient was reasonable and appropriate and air transport would be considered excessive in this case. As such, medical necessity is not established and the prior denials are upheld.

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)