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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 3/13/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an open nasal septal repair with turbinate reduction and possible cartilage graft.

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

The reviewer is a Medical Doctor who is board certified in General Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of an open nasal septal repair with turbinate reduction and possible cartilage graft.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Review Med and Dr. .

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Review Med: 1/9/13 UR worksheet, 1/14/13 report by Dr., 1/14/13 denial letter, 1/21/13 UR worksheet, 1/24/13 report by Dr., and 1/31/13 denial letter.

Dr.: 12/13/12 and 1/7/13 office notes by Dr. and 2/20/13 fax cover sheet with notes of a patient complaint via phone call.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The documentation was reviewed regarding the history and physical exam and the diagnostic study performed on the injured worker after sustaining an injury that resulted in a fractured nose with deviated septum. After the trauma, the patient complaint of bleeding and subsequently developed difficulty breathing and sensation of stuffy nose, and nasal airway obstruction. Physical examination including endoscopic examination revealed deviated septum and greater than 80% reduction in air flow to the affected nare.

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

This procedure is recommended by the ODG to correct anatomic deformity or deviation of the nasal septum, and it may be performed in response to an injury (nasal trauma). Nasal septoplasty is a procedure to correct anatomic deformity or deviation of the nasal septum. Its purpose is to restore the structure facilitating proper nasal function. Cosmetic enhancement, if any, is incidental. Because the septum is deviated in most adults, the potential exists for overutilization of septoplasty in asymptomatic individuals. The primary indication for surgical treatment of a deviated septum is nasal airway obstruction. Corrective surgery also is done to treat recurrent epistaxis associated with the septal deviation or sinusitis in which the deviation has a contributory role, and, occasionally, is necessary to gain access to another region such as the sphenoid, sella turcica or pituitary gland. In addition, septoplasty may be performed in response to an injury (nasal trauma), or in conjunction with cleft palate repair. Based on the patient's complaint and the physical findings, he meets the criteria for septoplasty. Therefore, the septoplasty is medically necessary in this patient per the ODG.

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
- 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)