

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Office Visit, comprehensive audiometry, tympanometry, otoacoustic emissions, tinnitus assessment, electrocochleography, auditory brainstem response testing and binocular microscopy

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

Board Certified Family 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Incident report dated 03/16/13

Audiometry results dated 03/16/13, 03/18/13

Clinical notes dated 03/16/13 – 03/27/13

Previous utilization reviews dated 03/25/13, 04/02/13, and 04/05/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury regarding her hearing after a headset she was wearing malfunctioned. Per clinical note dated 03/16/13, the patient stated that a power surge came through both ear phones causing immediate and severe pain. The patient reported immediate ringing in her ears at that time. The patient was also noted to have severe complaints of headaches. The clinical note dated 03/19/13 details the patient stating that she had been experiencing substantial improvement with the use of steroid therapy. The patient stated that she was able to sleep well. The audio results dated 03/18/13 confirmed the patient's improvement. Per clinical note dated 03/27/13, the patient rated her initial pain as 4/10. However, the severity of the pain was noted to be improving. Upon exam, the patient's tympanic membranes were noted to be normal without retraction, perforations, or erythema. The middle ear presented as normal and clear of effusion.

The previous utilization review dated 04/02/13 resulted in a denial secondary to a lack of information regarding objective findings which confirm the need for additional assessments.

The previous utilization review dated 04/05/13 also resulted in a denial for continued

evaluations secondary to a lack of objective findings to support the requested battery of tests.

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

The documentation submitted for review elaborates the patient complaining of bilateral ear pain. The office visit with additional hearing and vision tests would be indicated provided the patient meets specific criteria to include a significant occupational hearing or vision loss noted on exam. The recent clinical notes detail the patient stating that her hearing and pain associated with the initial incident were improving. Additionally, the patient was being treated with steroid therapy which was providing the patient with continued improvements. As no information was submitted regarding the patient's objective hearing or vision loss, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for an office visit, comprehensive audiometry, tympanometry, otoacoustic emissions, tinnitus assessment, electrocochleography, auditory brainstem response testing and binocular microscopy is not recommended as medically necessary 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)