



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 3/5/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

The item in dispute is the prospective medical necessity of a wide local excision facial scar, flap closure & advance.

**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 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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a wide local excision facial scar, flap closure & advance.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who was involved in a motor vehicle accident on xx/xx/xx. He suffered rib fractures, bilateral scapular fractures, and two left facial lacerations which were sutured. He has been evaluated for the more medial of the 2 lacerations. The scar is described on examination as being hypertrophic and thickened. The scar causes pain and inhibits normal facial animation due to its depth. He is unable to effectively close his mouth or left eye.

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

The claimant has a completely healed scar that is hypertrophic and causes a significant functional impairment, with pain and inhibition of normal facial

expressions. Based on the size, depth, and degree of hypertrophy of the scar, conservative treatment such as scar massage and topical or intralesional corticosteroids are not indicated as they would certainly not be efficacious. In summary, wide local excision of facial scar with flap closure and advance is medically necessary.

**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)**

Harrison's Principles of Internal Medicine, 18th edition