

Notice of Independent Review Decision

DATE OF REVIEW: 8/23/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

100 hours of in-home skilled nursing.

QUALIFICATIONS OF THE REVIEWER:

This reviewer obtained his Doctor of Medicine from the state University of New York Health Science Center at the Brooklyn College of Medicine in Brooklyn, New York. He also obtained a Master of Public Health from the Harvard School of Public Health in Boston, Massachusetts. He is a member of the International Spinal Cord Society, the American Medical Association, and the American Academy of PM&R. He has had numerous peer reviewed publications and is licensed in the states of New York and Massachusetts.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

100 hours of in-home skilled nursing. Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated 8/8/2007
2. Review organization note dated 8/16/2007
3. Request form note dated 6/27/2007
4. Denial note dated 8/16/2007
5. Clinical note by MD, dated 6/19/2007
6. Clinical note by MD, dated 6/25/2007
7. Case assignment note dated 8/8/2007
8. Clinical note by RN, dated 8/10/2007
9. Interlocutory orders note dated 1/19/2007
10. Clinic note by MD, dated 6/14/2007
11. Prescription note by MD, dated 6/14/2007
12. Medical necessity note by MD, dated 6/14/2007
13. Clinical note by RN, dated 6/20/2007 and 6/27/2007
14. Treatment plan note by MD, dated 10/20/2007 to 7/20/2007
15. Clinical note dated 8/10/2007
16. Review organization note dated 8/8/2007
17. Medical nursing care note by MD, dated 8/16/2007
18. Clinical note dated 6/21/2005
19. Clinical note dated 6/16/2005
20. Clinical note dated 6/16/2005
21. Clinical note dated 6/17/2005

22. Clinical note dated 6/8/2005
23. Request form note dated 5/29/2005 and 9/23/2005
24. Clinical note dated 5/19/2005
25. Clinical note by MD, dated 6/28/2005
26. Clinical note dated 6/30/2005
27. Clinical note by MD, dated 6/28/2005
28. Clinical note dated 6/28/2005
29. Clinical note dated 6/24/2005
30. Clinical note by RN, dated 6/24/2005
31. Clinical note by MD, dated 8/16/2007
32. Clinical note by MD, dated 7/19/2005
33. Clinical note dated 7/6/2005 and 7/12/2005
34. Request form dated 8/16/2007
35. Clinical note dated 7/7/2005
36. Prescription note dated 7/6/2005
37. Clinical note dated 7/6/2005
38. Clinical note dated 7/6/2005 and 7/12/2005
39. Clinical note by MD, dated 9/8/2005
40. Clinical note dated 9/6/2005
41. Clinical note by RN, dated 9/6/2005
42. Clinical note by MD, dated 8/15/2005
43. Clinical note by MD, dated 8/22/2005
44. Office visit note by MD, dated 8/30/2005
45. Clinical note by MD, dated 6/28/2005
46. Clinical note by MD, dated 5/20/2005
47. History and physical exam note by MD, dated 5/17/2005
48. Clinical note by MD, dated 8/31/2005
49. Clinical note dated 8/31/2005
50. Clinical note by RN, dated 8/31/2005
51. Clinical note by MD, dated 9/16/2005
52. Clinical note dated 9/31/2005
53. Clinical note by MD, dated 8/18/2005
54. Clinical note by MD, dated 8/15/2005
55. Clinical note by MD, dated 8/22/2005
56. Clinical note dated 6/20/2005
57. Progress note dated 6/29/2005
58. Clinical note by MD, dated 5/20/2005
59. Clinical note by MD, dated 3/2/2005
60. Clinical note dated 9/6/2005
61. Clinical note by MD, dated 11/4/2005
62. Clinical note dated 10/31/2005
63. Clinical note dated 10/21/2005
64. Deluxe power patient note dated 8/16/2005
65. Clinical note dated 9/2/2005
66. Clinical note dated 9/20/2005
67. Class information note by MD, dated 7/9/2005
68. Clinical note by MD, dated 9/16/2005
69. Clinical note by MD, dated 8/22/2005
70. Clinical note by MD, dated 9/16/2005
71. Clinic note by MD, dated 9/13/2005
72. Clinical note dated 9/13/2005
73. Administration record note dated 8/16/2005
74. Transcription report note dated 8/15/2005
75. Transcription report note by MD, dated 6/08/2005
76. Transcription report note by MD, dated 9/24/2004 and 3/22/2005
77. Department of neurology note by MD, dated 8/15/2005
78. Patient review of system note dated 8/15/2005
79. Physical medical and rehabilitation note by MD, dated 3/2/2005
80. Progress note dated 11/10/2004
81. Progress note dated 11/10/2004
82. Clinical note by MD, dated 8/16/2006
83. Physician's orders note dated 8/8/2006 and 8/9/2006
84. Service requested note dated 8/16/2007
85. Clinical note by MD, dated 8/15/2006
86. Clinical note dated 8/14/2006

87. Physician orders note dated 8/11/2006
88. Rehabilitation note by MD, dated 10/11/2006
89. Clinical note dated 10/12/2006
90. Physician orders note dated 10/6/2006
91. Clinical note dated 10/9/2006
92. Physician orders note dated 10/9/2006
93. Clinical note by MD, dated 6/4/2007
94. Pre authorization note dated 6/4/2007
95. Clinical note by RN, dated 5/29/2007
96. Nursing care note by RN, dated 5/25/2007
97. Plan of treatment note by MD, dated 1/20/2007 and 7/20/2007
98. Clinical note dated 5/31/2007
99. Rehabilitation note by MD, dated 6/19/2007
100. Clinical note dated 5/31/2007
101. Clinic note by MD, dated 6/14/2007
102. Prescription note by MD, dated 6/14/2007
103. Medical necessity note by MD, dated 6/14/2007
104. Clinical note by MD, dated 6/25/2007
105. Clinical note by RN, dated 6/20/2007
106. Clinic note by MD, dated 6/14/2007
107. Prescription note by MD, dated 6/14/2007
108. Medical necessity note by MD, dated 6/14/2007
109. Medical review dated 8/16/2007
110. Neuropsychological evaluation by Ph.D, dated 2/19/2004 and 2/26/2004
111. Clinical note dated 10/15/2003
112. Office neurology new patient report by MD, dated 11/12/2003
113. Office visit dated 7/31/2003
114. New patient visit by MD, dated 4/17/2003
115. Transcription report by MD dated 02/28/2007
116. Letter of medical necessity by MD dated 12/08/2006
117. Clinical note by MD dated 08/15/2005
118. Clinical note by MD dated 12/09/2005
119. Radiology imaging report by MD dated 11/22/2005
120. Clinical note by MD dated 08/15/2005
121. Clinical note dated 08/15/2005
122. Clinical note by MD dated 03/02/2005
123. Clinical note dated 04/27/2004
124. Request a hearing by dated 08/16/2007

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This xx year old male injured worker is noted to be diagnosed with brain damage and paraplegia due to spinal cord damage following an injury on the job during a trucking accident in 2003. Since his accident he has been confined to a wheelchair and has neuropathic extremity pain in all four extremities. He has also had some seizures and myoclonic activity. The injured worker takes multiple medications and requires 24 hour supervision and care giver assistance for his medication and ADLs. This case is under review to determine the medical necessity 100 hours of in-home skilled nursing.

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

There is no clear rationale for why skilled nursing specifically, and not unskilled home care, is needed on such a frequent or continuous basis. There is no documented significant skin compromise. There is no rationale, in addition, for why the patient is on intermittent catheterization if he cannot perform self-catheterization. In fact, it is reported that the patient is being straight-catheted eight times a day, which is not a reasonable frequency for anyone, even for someone who is self-cathing, and is a situation that demands a thorough discussion of why this program is in place. While SELF-intermittent catheterization (4-6 times a day, at most) is generally accepted to be a superior option for neurogenic bladder due to paraplegia, intermittent catheterization by a third party in the community (who is not a spouse) on a frequent and chronic basis is not a practically feasible option and is not, in fact, demonstrated in high grade studies to have superior long-term benefits on quality of life, morbidity, or mortality versus other bladder management options such as an indwelling urethral or suprapubic catheter. If a person with spinal cord injury has partial reflex voiding and requires cathing once per day for a complete emptying of the bladder, then intermittent cathing by a third party once per day is a reasonable option. In a patient with no reflex voiding, especially with an apparently small bladder capacity, intermittent cathing by a third non-spousal party 4 or 6 or 8 times per day is not reasonable, appropriate or more health-advantageous care.

Unskilled home health aides can provide supervision for safety, as well as assist in performing basic ADL care such as assisting with feeding, hygiene-related care, stretching/ROM, exercises, transfers, and weight shifting in bed and wheelchair. There is no rationale why the home health aide should perform meal prep except if the caregiver is not at home (i.e., when the caregiver is at work). There is no indication for home health to be performing laundry for a patient who does not live alone. Medication administration and monitoring for side effects can be performed by the patient's caregivers. Schedules utilizing long-acting medications should be used as much as possible to improve compliance, optimize analgesia, reduce drug level troughs, and so that these medications can be provided by caregivers. Notably, patients, including those with brain injury, are routinely sent to the community with changes in medications without the specific assignment of community skilled nursing to "monitor" for adverse effects. If complications are suspected, the doctor can be notified by phone by caregivers or an unskilled home health aide, which is what a skilled nurse would do as well. As sequelae of his injury, the patient does have an increased risk of adverse effects to medications or complications such as falls or other injuries. There is no published data that would support that there is a marginal benefit to having such frequent or continuous skilled nursing assistance over what would be attained with basic home health assistance.

The request for 80 additional hours of skilled nursing cannot be certified as medically necessary (on top of 20 skilled hours and 40 unskilled hours). The request for additional hours of home health care, however, is appropriate. Skilled nursing could visit the patient for now at a frequency of five days per week for two hours at a time for skin assessments, vital checks, assessing bowel and bladder care, weekly enemas, for providing ongoing caregiver education, and for overseeing and training the unskilled home care services (10 total hours per week, i.e., ten hours less than presently approved). If the patient remains stable and the home health aides have been adequately trained, these visits can be weaned as time progresses. The patient is elderly, he was involved in a serious work-related accident with subsequent paraplegia and brain injury, and his wife is working, so unskilled home health aides for a significant portion of each day (16 hours per day, x 5 weekdays or days that the patient's wife is working full-time; 8 hours per day on weekends or days when the wife is not working) is completely appropriate for the patient's health and well-being, as well as to reduce the likelihood of complications, including the need for further hospitalizations (96 hours per week of unskilled home health aide support). Some of the ten hours of skilled nursing should overlap with the unskilled care, if this is allowed by the plan, so that training of unskilled care can continue on an ongoing forward basis, to optimize the skills of the home health aides, as well as (in part) to accommodate for turnover of unskilled help.

In summary, none of the requested additional 100 hours of in-home skilled nursing (RN, LPN level services) can be certified as medically necessary. The previous denial is upheld.

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

- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
MILLIMAN CARE GUIDELINES
- X 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)

There are no directly pertinent studies in the peer-reviewed experimental literature that would be relevant as resources for the present case. The bases of the recommendations are safety issues, and impairment issues with respect to ADLs due to brain injury and spinal cord injury.

AMR Tracking Num: 36900