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AMENDED
MARCH 10, 2008

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Home health aide services 76 hours per week and skilled nursing services 20 hours per week from January 1, 2008, through July 1, 2008.

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

The physician providing this review is a physician, doctor of medicine. The reviewer is national board certified in physical medicine and rehabilitation. The reviewer is a member of American Academy of Physical Medicine and Rehabilitation. The reviewer has been in active practice for twenty-three years.

REVIEW OUTCOME

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

☒ Overturned (Disagree)

Medical documentation supports the medical necessity of Home health aide services 76 hours per week and skilled nursing services 20 hours per week from January 1, 2008, through July 1, 2008.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Multiple providers

- Office notes, hospitalizations, diagnostics, procedures, home health and nursing care, and rehabilitation (11/01/02 – 02/15/08)
- IRO (08/23/07)
- Utilization reviews (01/14/08 – 01/25/08)

Criteria used for denials:

- ODG 2008, Pain Chapter,
- Centers for Medicare & Medicaid Services (CMS), 2004, Home Care Guidelines.
- Alternate Level of Care (ALOC) Guidelines.
- Physical Medicine and Rehabilitation: Principles and Practice, 4th edition (October 30, 2004)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old who was involved in a motor vehicle accident (MVA) on xx/xx/xx. His truck went off a bridge and he sustained injuries to multiple body parts.

2002 – 2003: Following the injury, the patient was admitted at Hospital. On arrival, he was in a combative state and therefore was intubated. Computerized tomography (CT) of the head revealed a small inter-hemispheric subdural hematoma. CT of the thorax demonstrated multiple rib fractures on the right side as well as a complex right scapular fracture and bilateral posterior lung contusions. X-rays of the thoracic spine demonstrated a burst fracture of the T11 vertebra with a retropulsed fragment causing approximately 50% spinal canal compromise. In addition, there were multiple fractures of the spinous processes in the thoracic vertebra column as well as a transverse process fracture of T10 on the right. It was found that the patient had no movement of his lower extremities. He underwent bilateral laminectomy of the T11 with removal of the retropulsed bone fragments and closure of a complex dural tear followed by arthrodesis from T9 through L1 with instrumentation. A repeat procedure of posterior arthrodesis from T8 through L2 was performed with reinsertion of spinal instrumentation. He was discharged in stable condition and on multiple medications (anti-depressant, anti-coagulant, prednisone, and narcotic medication). On discharge, he was treated with inpatient rehabilitation therapy for the diagnosis of T11 ASIA-A spinal cord injury. Thereafter, he developed myriad of problems including deep venous thrombosis (DVT) of the lower extremities, bowel dysfunction and incontinence, recurrent fecal impactions, umbilical hernia, recurrent urinary tract infection (UTI), right shoulder rotator cuff tear, depression, post-traumatic stress disorder (PTSD), and delayed gallbladder emptying. He underwent laparoscopic colostomy and repair of umbilical hernia on January 27, 2003, and laparoscopic cholecystectomy on October 16, 2003.

M.D., recommended admission for DVT management, proper equipments for functional mobility including manual and motorized wheelchair, hospital bed, adaptive bathroom equipment, seating system, Hoyer lift, and complete home modifications. M.D., a designated doctor, felt that further improvement in cognitive function was not expected and it did not appear to be caused by depression or medications.

2004 – 2005: During this period, patient's condition remained more or less the same and he was majorly treated with home health and nursing care. He was maintained on multiple pain medications but his abdominal pain remained

refractory. A peer reviewer opined the initial treatment had been reasonable and necessary; however, respiratory and gallbladder problems were not related to the MVA. On June 22, 2004, the patient underwent placement of an intrathecal catheter. However, intrathecal therapy failed to provide any significant improvement. In February 2005, he was admitted to Medical Center for inpatient rehabilitation.

In multiple medical record reviews, M.D., rendered the following opinions: (1) The patient's narcotic usage was excessive. It was doubtful whether he was ingesting these medications and should undergo further investigation. (2) Use of Ambien, Seroquel, Actiq, imipramine, Gabitril, and cyclobenzaprine was not reasonable. Use of methenamine (on occasions), fluoxetine, butalbital or hydrocodone, and Duragesic patch was reasonable. (3) Medical supplies were reasonable but quantities were mis-stated. (4) A neuromuscular stimulator was not necessary.

2006 - 2007: The patient continued to receive home and nursing care. The patient was managed on multiple medications and was recommended a trial of dorsal column stimulator (DCS).

In April 2006, he fell from his chair sustaining fracture of the left femur. On May 4, 2006, he underwent closed reduction and intramedullary trochanteric nailing of the left femoral shaft fracture. In June 2006, he was re-admitted for sacral decubitus ulcer and fever and was treated for perirectal abscess, UTI, and severe neuropathic pain. On August 2, 2006, he underwent debridement of skin, subcutaneous tissue, muscle, and bone for stage IV right ischial decubitus ulcer. In September 2006, he was re-admitted and was found to have Methicillin-resistant Staphylococcus aureus (MRSA) osteomyelitis of the right ischium and inferior pubic ramus. On November 10, 2006, the patient underwent repair of right ischial decubitus ulcer with fasciocutaneous flap and inferiorly-based muscle flap. Followed by this, he underwent inpatient nursing care, wound care, and medication management.

In a peer review, Dr. opined as: *The home health care had not achieved the goals required for this paraplegic patient and the basic requirements to deal with all of the medical issues could not be addressed in the home. At a minimum, he would require a long term care facility that could provide nursing and medical care on a supervised level. Additionally, the care should be supervised by a physiatrist.*

In December 2006, the patient was admitted for continuation of wound care and physical rehabilitation for a period of five weeks. On discharge, he was continuously attended with home care and nursing care and was treated with intravenous antibiotics. The skilled and unskilled nursing care was provided through December 2007 by Agency. M.D., assessed organic affective disorder and iatrogenic opioid dependence and recommended either an infusion spinal pump or spinal cord stimulator.

In June 2007, Dr. issued a letter of medical necessity for the following services: *24 hour supervision and caregiver assistance as well as licensed nursing services, medication dispensing and assessment, catheterization, total colostomy care, weekly enemas and occasional bowel irrigation, assessment for bedsores and overall health, and assistance for activities of daily living (ADL).*

The request was made for 100 hours of skilled nursing per week and 40 hours of unskilled nursing per week. 40 hours of unskilled nursing and only 20 hours of skilled nursing per week was authorized. The additional 80 hours of skilled nursing was referred to an IRO. The IRO decision was given on August 23, 2007, and the disputed additional 80 hours of skilled nursing visit was upheld. The IRO reviewer recommended a total of 96 hours of unskilled nursing and only 10 hours of skilled nursing. After the IRO determination, an agreement of 76 hours of unskilled nursing and 10 hours of skilled nursing was reached in September 2007. In November 2007, the hours progressed from 10 to 40 hours of skilled nursing plus 76 hours of unskilled nursing.

In September 2007, the patient was admitted for right gluteal cellulitis, UTI, delirium, and obstructive sleep apnea. He was also managed for hypertension, type II diabetes (steroid induced glucose intolerance), hypothyroidism, and DVT.

Patient's lab showed elevated prothrombin time (PT), international normalized ratio (INR), hemoglobin A1c, glucose, and creatinine. He was seen by the health providers for the complaints of swelling over the penis and foreskin, ulceration on the right lateral side of penis, redness and warmth in the left upper leg, and persistent cough and asthma. He was continued on the same medications.

2008:

In January, patient's partial thromboplastin time (PTT), PT, INR, electrolytes, and A1-c were elevated and he had persistent cough. In January, a request for 76 hours of home health aide per week and skilled nursing visits two times a day (each of two hours duration) was made. The request was for the period from January 1, 2008, through July 1, 2008.

The request was denied with the following rationale: *There is insufficient documented information/data from the requesting provider supporting this request. In addition, achievable information suggests home health services are not effective as this patient's health continues to deteriorate.*

M.D., the treating physician, issued a letter of medical necessity stating: *The patient suffered a spinal cord injury as a result of the accident which has resulted in his being paraplegic and dependent on assistance for performance of a number of ADL. The patient is being cared for at home by his wife with assistance of nurses and nurses aides during the day while patient's wife is at work. We are requesting approval of 76 hours per week of home health aide and 20 hours per week skilled nursing care which I feel are necessary and reasonable for proper care of his needs. He has use of his upper extremities but has no use of whatsoever of the lower extremities and is therefore is totally*

dependent upon assistance to get in and out of bed. He requires assistance with meal preparation, monitoring of his blood glucose, injections of his insulin for control of his diabetes, changing of his Foley catheter bag, emptying of his colostomy bag, dressing and undressing, preparing his medications for breathing treatments, and repositioning himself in bed. With the disabilities he has to contend with, it is apparent that he requires assistance during the day with ADLs and he also cannot be safely left alone at night due to the possibility of an emergency for which he would require assistance in getting into his wheelchair to evacuate the house, receive a breathing treatment, treat an episode of hypoglycemia, or need help to deal with any number of other urgent or emergent situations.

The request for the reconsideration of the home health services was denied with the following rationale: *After review of the records, it is my opinion that skilled nursing visits for two hours per day is not appropriate to manage this patient and that the patient can be adequately cared for with a home health aide six hours per day for a total of 42 hours per week.*

In February, the patient had pressure sore over the right buttock and a coffee burn on the right shoulder and left flank tenderness. Orders were written for the home health to clean and dress the ulcer and medications were continued.

OVERALL DIAGNOSTIC IMPRESSION: Asthma, paraplegia, type II diabetes, hypertension, neurogenic bladder, GERD, hyperlipidemia, benign hypothyroidism, and long term use of anticoagulants.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. THIS PATIENT CAN BE MAINTAINED AT HOME WHICH IS THE DECISION OF THE TREATING PHYSICIAN AND THE PATIENT. BASED ON THE COMPLEXITY OF THE CASE THE REQUEST FOR SKILLED NURSING AND NON SKILLED IS REASONABLE. THIS IS NOT THE TYPICAL PARAPLEGIC OR CHRONIC PAIN PATIENT AS THERE ARE MULTIPLE ISSUES, INCLUDING DECUBITUS ULCER, CELLUITIS, UTI'S AND DIABETES TO NAME A FEW. THE REQUEST IS APPROPRIATE.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS