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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Home Health Aid Care 5 hrs a day x 7 days a week for 30 days

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

M.D., Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. The patient had left lower extremity severe trauma and facial and head trauma. The patient was diagnosed with left tib/fib fracture and severe head injuries with large scalp laceration. The patient was taken by life flight to and was managed from xx/xx/xx – xx/xx/xx, at which time he was transferred and admitted to Healthcare SW. The patient was subsequently transferred to Xxxx on 02/03/11. Note dated 06/02/11 indicates that the patient spent several weeks at Neuro Recovery Center and had a syncopal episode that was apparently a seizure. The patient was apparently released home on 06/01/11. The patient was not walking on his own and not transferring or doing ADLs. CT of the brain dated 06/24/11 revealed multiple areas of encephalomalacia and atrophy involving the left cerebral hemisphere compatible with post infarct or posttraumatic changes in this region. No acute abnormality is noted. Note dated 07/13/11 indicates that the patient is doing well with therapy and with speech therapy. He is getting around better and less inflammation. Note dated 07/27/11 indicates that the patient's wife is taking care of him 24 hours a day, 7 days a week. The patient is going to be seeing TIRR on or about 08/10/11. Note dated 09/28/11 indicates that the patient is unable to walk safely without stopping. He is no longer able to complete feeding, grooming or even toileting on his own without assistance. The patient is unable to use a cane or walker because of the hemiplegia and a manual wheelchair is reported to be inappropriate for the same reason. Note dated 09/28/11 indicates that current medications include Zyprexa, Meloxicam,

Kombiglyze, and Keppra.

Initial request for home health aide care was non-certified on 09/26/11 noting that records reflect the patient did participate in outpatient physical therapy. No physical therapy notes were provided, but the patient is apparently not home bound since he is participating in outpatient physical therapy at this time.

The records do not reflect that the patient is home bound at this time or lacks family support to provide the care possibly needed on a continued basis. The denial was upheld on appeal dated 10/05/11 noting that the specific activities that the home health care personnel provided based on weekly time sheet and service reports were home making activities and personal care services. These activities are not considered as medical treatment per guidelines. There is no documentation of specific medical treatment that was provided to the patient during the previous home health aide visits.

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

The submitted records fail to establish that the patient is homebound on a part time or intermittent basis, as required by the Official Disability Guidelines. The patient is noted to be participating in outpatient physical therapy. The submitted records indicate that the patient's wife is taking care of him 24 hours a day 7 days a week. The submitted weekly time sheets from previous home health care indicate that services rendered were home making activities and personal care services. The Official Disability Guidelines note that these activities are not considered medical treatment. Given the current clinical data, the request for Home Health Aid Care 5 hrs a day x 7 days a week for 30 days is not medically necessary at this time.

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)