



Notice of Independent Review Decision-WCN

CLAIMS EVAL REVIEWER REPORT - WCN

DATE OF REVIEW: 8-24-11(AMENDED 8/31/11)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Home Health Aid 6 hours per week

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

3-8-08 Surgery performed by Dr.: T12 thoracic corpectomy. Arthrodesis from T11 to L1. Application of anterior cervical rotation with Synthes TSLP plate, implantation of parasthetic device with Synthes Synex cage 36-56 mm. autograph preparation.

3-8-08 through 3-17-08 Hospital - the claimant fell in store and sustained T12 fracture with canal compromise with paraplegia of L4-L5 with subluxation and questionable sacral fracture. He was transported to the hospital and consulted to neurosurgery. He was admitted to the intensive care unit. Repair of his thoracic spine was performed. He was transferred to the floor. He had a chest tube, physical therapy and occupational therapy. He regained a significant amount of function to the lower extremities. However, he still has incomplete paresthesia and coordination deficit. He is to transfer him to. He is healing well.

3-17- Rehab Hospital - the claimant A, right hand dominant male was working when a tractor rolled-over-and fell on top of the claimant. The patient was life flighted from the Jasper area to Hospital in Texas where he was admitted and treated by the Trauma Surgery Service. He was admitted by Dr. His workup revealed a T12 burst fracture with retropulsion of bone fragments into the canal with impingement of the conus and edema in the conus, some endplate compression fractures at T8 and T10, severe bilateral L4-5 level foraminal stenosis, and grade 2 spondylolisthesis with L4 spondylolysis. Separately the abdominal and pelvic CT scan with IV contrast done on the date of the trauma, 3/8/08, was interpreted as showing the main vertebral body fracture and described the L4-5 lesion as being severe chronic lumbar spine disease with chronic subluxation. Also noted were vascular calcifications and enlargement of the prostate gland. Dr/ was consulted. He apparently reviewed the films. He noted the L4-5 spondylolisthesis with spondylolysis was congenital type at L4-5. There was sacralization of the L5 vertebral body. There was about a 50% height loss of the T12 vertebral fracture. The patient's lab work showed normal renal function and initially unremarkable electrolytes. He had an elevated white count and normal hemoglobin and hematocrit acutely. The patient states he never had loss of consciousness or any head trauma at the time of the injury. The patient underwent spine surgery by Dr. on 3/10/08 which was done in coordination with the trauma surgeon, Dr.. The patient underwent left side approach through the diaphragm by Dr. and then Dr. performed a T12 corpectomy, arthrodesis from T11 to L1 with implant of prosthetic hardware and bone autograft for fusion. Closure of the incision with reapproximation of diaphragm and chest tube placement on the left was done by the trauma surgeon. He is an appropriate acute inpatient rehabilitation hospital candidate. He needs around-the-clock skilled nursing care and monitoring and management of his rehabilitation needs by a Physical Medicine Rehabilitation physician and the intensity of an at least 3 hour per day therapy program with all of the above noted disciplines.

Physical therapy from 4-1-08 through 6-11-08

5-6-08 Limited ultrasound of the lower abdomen showed small amount of ascitis of the left abdomen. The significance of this finding is uncertain. This is situated to the left of the urinary bladder.

5-8-08 CT of abdomen and pelvis shows postop changes T11 though L1 with postop changes at least within left rib 10. Mild left pleural thickening and minimal left pleural

effusion with atelectasis, minimal infiltrate or scarring in the left lung base. Mildly prominent bowel loops, small bowel apparently more affected than the colon, suggesting ileus although some element of very early small bowel obstruction not excluded. Possible minimal amount of free fluid in the lower pelvis. Mild hepatosplenomegaly, new since previous study. Chronic findings including spondylolysis and spondylolisthesis L4, atherosclerosis, spondylosis, tiny low attenuation lesion right kidney possibly cyst but too small to definitely characterize, all stable.

6-3-09 Urodynamic testing.

Daily treatment notes from 6-18-08 through 10-10-08.

6-11-08 through 6-18-08 Rehab Hospital. This right-hand dominant male sustained an injury while on the job that included a T12 burst fracture with retropulsion and bone fragments into the canal and impingement on the conus medullaris and edema noted in the conus medullaris and sustained several other fractures as well on 3/8/08. He had a residual incomplete sensory motor paraparesis and neurogenic bladder and bowel as a result due to the spinal cord conus medullaris lesion. He had undergone a left side thoracotomy for T12 corpectomy and decompression of the conus medullaris and T11 to L1 fusion with spinal cage prosthetic device and bone autograft material fusion on 3/10/08. He was admitted here for spinal cord rehabilitation.

6-26-08 Complex CMG was performed showing large bladder capacity with normal compliance and no evidence of detrusor overactivity. Markedly delayed bladder sensation, consistent with neurogenic insult or injury.

6-27-08 MD., the claimant completed his rehab in. He is now living in an assisted living facility. His fusion is doing well.

6-27-08 X-rays of the ribs shows old left 7th and 8th rib fractures identified posteriorly. The left 9th rib appears to have been partially resected.

6-27-08 X-rays of the thoracic spine shows spinal fusion hardware present from T11 to L1 with previous partial corpectomy at T12. Compression deformities at T8 and T10 may be chronic.

6-27-08 X-rays of the lumbar spine shows spinal fusion hardware seen from T11 to L1. The spine is curved to the level at this level as well. Minimal anterior compression deformity at L4 has a chronic appearance L5 is transitional and there appears to be at least grade 1-2 anterolisthesis of L4 on L5. Disc space height narrowing is noted at this level. No clear acute fracture can be delineated. Extensive atherosclerotic disease is noted.

7-15-08 MD., medications were discussed with the case management.

8-4-08 MD., the claimant is status post T12 corpectomy and fusion is doing well. The evaluator prescribed a TENS unit.

8-26-08 MD., the claimant is a male with history of work-related accident in xx/xxxx. Patient required a thoracic fusion from T11 to L2 by Dr. because of a burst fracture at T12 causing incomplete spinal cord injury. Patient has been living in an assisted living

facility. Patient reports no significant change in the last 6 to 7 weeks. He discussed his medications with him today He believes he can cut back and possibly discontinue Mirapex and Lamictal. Also plan to discontinue vitamin D and calcium. It appears he did have the AFOs adjusted and they do fit better today. Physical exam: Patient is in a wheelchair with no movement in the legs. Plan: will continue with Neurontin, Remeron, Flomax, Skelaxin, Lorcet, and Dulcolax. He believed patient should be able to monitor the narcotic closely. He was able to discontinue several medications today. He believed he was discharged on fairly large amount of medications from the Rehab Hospital. He wrote prescriptions enough for one month Will have him return one month

10-23-08 MD., the claimant was seen due to abdominal pain. The claimant's abdominal pain seems to be neuropathic in origin, as it is originating from his back and is in a ring like pattern across the abdomen with the character of needles sticking in the abdomen. He had a CT done in May 2008, which showed postop changes in the spine, mild left pleural thickening and mildly prominent bowel loops, however, because of persistent symptoms, he recommended repeat CT scan of the abdomen and pelvis for further evaluation.

Psychological progress notes on 6-3-08, 12-10-08, 1-7-09.

12-8-08 MD., the claimant is status post a T12 corpectomy for severe burst fracture he sustained on xx/xx/xxxx while working. He states he has some lower back spasms. Other than that, he is remaining stable. He is able to, at times, walk with his walker. He states he has some anxiety and his nurse case manager tells me they have an appointment with Dr. for a neuropsychological evaluation. He has also seen the GI specialist in Houston and they are planning to refer him to a neurologist. He does have a special van that he tries to drive and get around in. He tells me he is planning to try and go to visit his family. On examination, he is continuing to have the bilateral footdrop. He wears his AFOs. He is in a wheel chair. His wound is well healed. Back: He has some paraspinous spasms towards the left. There is no palpable step off. He has negative straight leg raising. He is alert and oriented x 3. Sensory: He continues to have the stocking-glove distribution in the bilateral lower extremities. He will return in three months. He will continue to follow up with his pain management physician, Dr. He was going to give him some Voltaren gel he can apply to his lumbar region to see if this will give him any relief. He gave him some Cymbalta 30 mg samples he could take at night to see if it would help him rest and help with his anxiety and chronic pain as well.

12-12-08 Home Evaluation. The claimant lives in a one story home alone. His home was recently remodeled to accommodate his newly acquired disability which requires him to use an electric wheelchair, manual wheelchair and/or a rolling walker within and outside of his home. His bathroom was remodeled for him to use independently. He has a floor level bathtub that is surrounded by 3 walls and the 4th side has a tile surround. He stated during the interview that he has difficulty getting out of the bathtub. He stated he might benefit from grab bars on both sides of the tub. However, a grab bar on the tile surround would get in the way of him scooting into the tub. A grab bar on the opposite long wall would not work either due to the height of the bathtub. The grab bar would have to be installed at an awkward height that would not assist him getting into or out of the bathtub. After discussing this with him he stated he doesn't bathe very often anyway and could manage. He stated he has no difficulties using the toilet or the walk in shower. The claimant stated he can easily access his clothing with the double rods in his closet. The claimant stated he has difficulty getting into and out of the van due to

the concrete pad being too small. As you can see in the picture the concrete pad should be extended so the wheelchair does not get into the grassy or muddy area. Even with the van parked at the opposite edge of the concrete, the pad is too narrow. Currently there is no turning room to turn into the lift. Four feet should be added to the left of the van in the picture. This will accommodate the length of the electric wheelchair. The area next to the concrete pad can become very muddy and therefore he cannot park on the dirt/mud. The concrete pad and walkway should be covered. It takes at least 5 minutes to get from inside the van, down the lift and to the enclosed porch and vice versa. The claimant is not able to leave in the rain or must endure being wet from the amount of time it takes to get into and out of the van. The electrical components of the electric wheelchair must also stay dry for the system to operate correctly. The kitchen area poses the most difficulty for the claimant. He typically uses his electric wheelchair for mobility. Even with the manual wheelchair or his walker he is not able to access the back of the kitchen cabinets. In standing he is unable to safely bend down or over to reach the back of the cabinets. He is also not able to reach more than the shelf on the upper cabinets. The upper cabinets should be lowered by 4 inches. He knows the coffee pot must be moved forward due to its height when the cabinets are lowered. Everything else on the countertop will be fine. The left most bottom cabinet where the sink is located needs one rollout drawer on the bottom. There is a half-shelf in the middle so no second rollout should be placed in this bottom cabinet. The bottom cabinet directly under the sink has many wires and supply lines. The two small bottom cabinets directly on each side of this cabinet also have supply lines near the back. No rollout drawers are recommended here or under the sink. The claimant keeps his food items and cooking pots to the right of the range. He would benefit from rollout drawers behind the first two doors. He would not be able to use drawers behind the third door due to the position (it would hit the range). There are 3 shelves behind the first door and 2 shelves behind the second door. The table is at a great height for food preparation. However, it is very large and difficult to move around to access the different areas of the kitchen. He could benefit from the bottom of the table legs being cut down and locking wheels added. The table should remain at the current height. Therefore, if 3" or 4" locking wheels are added to the legs that much should be removed first 3" or 4" locking wheels would be appropriate. The locks should be easily set and released with a stick. He was in agreement with this proposal. He also stated "Maybe I'll just go buy a butcher block table". He requested the refrigerator be moved next to the range and the counter currently next to the range be moved to the wall. This is not recommended and we discussed why I am not recommending. He needs a place to set items on besides the stovetop. If he is cooking on the top and in the oven he would have no place to set the oven food without moving his chair-not safe. I did check and the counter and its top are not connected to the wall. The refrigerator is not connected to the wall. It would be very easy to move.

12-17-08 US retroperitoneal exam due to neurogenic bladder showed normal sonographic appearance of the kidneys. Limited evaluation of a partially distended bladder, neurogenic bladder. Prominent prostate.

12-17-08 MD., the claimant is having some penile sensations prior to needing to void. Of note, he had urine submitted for culture by his doctor and this grew out pansensitive

E coli which was treated with nitrofurantoin. The plan is to repeat the urine culture. He will also get an ultrasound.

1-20-09 MD., the claimant presented with abdominal pain with incontinence. His bladder incontinence and bowel incontinence and sexual discomfort are due to his spinal cord injury. He also has some radicular symptoms in the lower abdomen arising from the lower thoracic spine injury.

1-21-09 MD., the claimant is a male with history of work-related accident xx/xxxx. He had a T12 burst fracture resulting in spinal cord injury He required thoracic fusion by Dr.. He was at under Dr. care He had been following him as an outpatient. He continues using a wheelchair. He has seen urologist in Houston who is following him for neurogenic bladder. He saw a neurologist also recently who informed patient not much more could be done for him. He also saw gastroenterologist who thought his abdominal pain was neurogenic. Patient requests Viagra today. He did not have physical therapy and requests another prescription for therapy. He also requests prescription for Roho cushion He states he lost last one. He continues taking multiple medications including, Lorcet, Dulcolax, Skelaxin, Flomax, Remeron, Neurontin. Physical exam: patient in wheelchair with no lower extremity movement. He talked with patient and case manager for about 15 or 20 minutes about multiple issues concerning his spinal cord injury. Will reorder physical therapy at patient's request since he did not receive it in October. Also will prescription for Viagra and wheelchair cushion. Will see patient back in 3 months and will do phone refills on medications through mail order pharmacy.

1-21-09 Neuropsychological progress note: The claimant was seen today for followup in my office. He started off the session today by indicating that he had seen a neurologist in Baytown yesterday. He stated that the neurologist examined him thoroughly. Afterwards, he reportedly told The claimant that there was nothing that he could do from a neurological standpoint to help the claimant. He suggested that the claimant would have to "learn to live with it". The claimant was obviously concerned about this bleak prognosis. On the other hand, he stated that he is scheduled to see Dr. tomorrow. Dr. is one of the physical rehabilitation doctors who had seen him previously. He and the case manager will be talking with Dr. about getting followup physical therapy services. The claimant is hoping that with additional therapies he may regain more functional use of his lower extremities. He recognizes that this will be a slow process. On a positive note, the claimant stated that he has had a number of social developments that are encouraging for him. Through one of his online contacts he met a school teacher. The two of them have been seeing one another on a social basis. He indicated that the lady seems very interested in developing a relationship with him. In fact, they talked about possibly going together to visit his son. She has agreed to go with him, something that he sees as a positive development and possibly as an indication that she is interested in a more long-term relationship. He has been very gratified by this, especially considering the fact that his ex-girlfriend has been giving him more signs that she is not interested in being anything more than "a friend". The claimant seems to feel better about things now that there is another possible relationship developing for him.

Aside from these issues. The claimant indicated that things are about the same. He would like to continue seeing me every couple of weeks for supportive therapy. I will continue to work on issues as they arise. Our next appointment is scheduled in 2 weeks.

Physical therapy from 1-28-09 through 5-29-09.

2-20-09 MD., the claimant was seen due to left upper quadrant pain, rectal bleeding and constipation.

3-5-09 endoscopy performed by Dr. due to hematochezia. Findings: Small internal hemorrhoids and small colonic polyp.

4-7-09 MD., evaluated the claimant to review the result of his biopsies. The claimant has constipation currently well control. He has some tenderness in the abdominal wall area. He will be referred to a specialist. His colonoscopy is negative.

4-21-09 MD., the claimant is a male with history of work related accident in xx/xxxx, resulting in a T12 burst fracture and a spinal cord injury. Patient required surgical intervention by Dr for stabilization. Patient continues requiring left wheelchair for mobility. Patient continues having abdominal pain Patient saw gastroenterologist and a workup which was basically negative The gastroenterologist suggested abdominal CT scan with contrast to complete workup. Patient continues taking multiple medications including Dulcolax suppository, Viagra, Cymbalta, and Mirapex. Patient continues having difficulty with any type of ambulation There was a report by physical therapist. It states patient requires assistance for many self-care activities. It does not appear patient will improve. He is over one year postop. Objective: Physical exam: Still significant weakness in lower extremities Assessment: Spinal cord injury. Plan: Will obtain abdominal CT as suggested by gastrologist to complete GI workup. He continues having left thoracic rib cage pain he did tell him he believed it has to do with the thoracotomy from surgery but will request the CT of the abdomen. If any abnormalities, will refer to general surgeon. Patient also still requires 4 hours per week of assistance to do his self-care skills. This will probably not change since his lower extremity strength will probably not improve. He refilled medications for him also. Will see him back after CT is done

6-3-09 Urology procedure shows essentially normal urodynamics study with some reduction in the overall capacity, but otherwise is without harmful pressure configuration. The evaluator recommended creatinine, renal ultrasound, urine culture and sensitivity now.

6-11-09 Renal Ultrasound shows possible thickening of the urinary bladder wall although it was not completely filled and is therefore, inadequately evaluated. Prominent prostate. Kidneys appear normal bilaterally.

7-20-09 MD., the claimant is a pleasant male with history of work accident in xx/xxxx resulting in T12 burst fracture and spinal cord injury Patient required surgery by Dr for stabilization He continues having T11 spinal cord injury He continues having some mild depression He also has some muscle spasms He denies any significant change in last several months and continues taking the same medications Objective: Physical Exam Patient in the wheelchair No acute distress No movement of legs Reports vague abdominal pain still present. Assessment: Spinal cord injury. Plan: Patient was told previously that his abdominal CT scan was basically negative he told him he did not know the etiology of his abdominal pain other than possibly related to the spinal cord injury he refilled several medications with 3 month supply today. He will see patient back in 3 months.

12-14-09 MD., the claimant is status post a T12 corpectomy and stabilization on March 10, 2008. He is coming in for his checkup. He is able to drive his van. He tells me that he may go in the spring to Albany, New York to visit his family, when the weather is better. He continues to take some Skelaxin, Cymbalta, Neurontin, Vicodin, and Lamictal. He is recently out of his Lamictal and Dr. is out of town, so he asked us to refill these. He now has lifetime income benefits after he saw Dr. for a disability opinion. His grabber is broken and he needs a new one so it can assist with activities of daily living. On examination, he is alert and oriented x3. Motor is 5+/5+. He has bilateral foot drop. Sensory is intact. There is a slight dysesthesia in his left shin. His wound is well healed. The back is nontender. Negative straight leg raising.

Impression: Status post thoracic fusion, doing well, lumbago. He will return in 4-6 months, prescription for a grabber, refill Lamictal, Vitamin B6.

2-1-10 MD., the claimant is a pleasant male with history of work accident in xx/xxxx resulting in T12 burst fracture and spinal cord injury Patient continues to have moderate back pain. He continues being modified independent for self-care activities. He requires an electric wheelchair. He has a provider coming in twice a week to do heavy household chores. He continues taking multiple medications including, Lorcet for pain. He receives other medications mail-order which include Cymbalta, Flomax and Lamictal. Objective: Physical exam: H&E wheelchair and reports moderate back pain. Not able to move legs Assessment: Status post spinal cord injury Plan: Will have patient continue with present medications He receives most medications through a mail-order pharmacy he will write prescription for Lorcet today. He wrote one for 90 which is lasting several months He understands not to receive any narcotics from other physicians. He reported some complaints consistent with vertigo. He informed him he did not believe that this has to due to spinal cord injury he needs to see his primary care doctor Will see patient back in 3 or 4 months.

4-13-10 MD., the claimant has two other problems in addition to thoracic myelopathy, which he had known of before. He complains of a lot of discoloration and numbness and pain in his feet bilaterally. This has been bothering him quite a bit. Most of his symptoms are below his knee. He has changes in the color and coldness of the feet, and redness of his skin, as well as pain. The other problem he has is intermittent vertigo. Whenever he turns his neck upward or to the side, he gets severe vertigo with almost complete

loss of vision, and this is bothering him quite a bit. This is not associated with any other signs or symptoms. On exam, his blood pressure, pulse rate, cardiovascular and respiratory systems and carotid arteries are normal. His neurological examination shows evidence of myelopathy as before because of previous spinal cord injury which has not changed. Also when he examined him, peripheral pulses bilaterally appeared to be poor. The symptoms he describes in his lower extremity can be due to changes in his sympathetic nervous system. This seems to be related to vertebrobasilar insufficiency. He needs to be worked up for that. He will do an MRI of the brain and an MRA of the carotid arteries and intracranial arteries as well as Doppler studies of the lower extremity for peripheral vascular disease. He will evaluate him after these are done.

4-28-10 MRI of the brain shows no evidence of an acute intracranial process.

4-28-10 MRA of the brain was unremarkable.

4-28-10 Bilateral lower extremity arterial Doppler shows findings suggesting hemodynamically significant stenosis bilateral common femoral right proximal and mid superficial femoral, left popliteal and right posterior tibial arteries. Findings consistent with non hemodynamically significant stenosis left superficial femoral, right popliteal and right peroneal arteries.

5-5-10 MD., the studies of the brain were normal; however, the studies of the lower extremity arteries showed significant blockage of the femoral arteries bilaterally. This can explain part of his symptoms in the lower extremity. This needs to be confirmed with a CTA, and if this is confirmed for peripheral vascular disease, we will see if it can be corrected.

5-19-10 CTA of the abdominal aorta showed atherosclerotic vascular disease with calcified and nonhomogeneous calcified plaque. No evidence of an aneurysm, dissection, significant stenosis or other significant abnormalities.

5-19-10 CTA of bilateral lower extremity arteries showed bilateral predominantly calcified plaque from the level of the common iliac to the superficial femoral arteries. Non hemodynamically significant stenosis bilaterally involving the common/external iliacs, common femoral, superficial femoral and bilateral anterior and posterior tibial arteries. Findings consistent with occlusion bilaterally of the proximal peroneal arteries.

5-24-10 MD., the claimant is a pleasant male with work injury in xxxx resulting in T12 burst fracture and spinal cord injury. Patient continues taking Lorcet for pain. He takes about one per day. He also takes Cymbalta, Flomax, and Lamictal He works doing fairly well the last several months He continues to use wheelchair for most of his transportation. He has home health come in and provide assistance. He states that they have been doing 4 hours per week and he needs 6 hours per week. Physical exam: Patient in wheelchair with boots on, patient reports moderate back and neck pain.

Assessment: Status post spinal cord injury. Plan: Will plan to continue with Lorcet he wrote prescription for 90. Last refill was in February he also will write a prescription for his home health aide to be increased to 6 hours per week at his request. He will call for refills and other medications if needed he encouraged him to continue to be as active as possible with his wheelchair. He will see patient back in 3 or 4 months

6-9-10 MD., the evaluator did a CTA of the abdomen and lower extremities. He does have blockage of both peroneal arteries for which nothing can be done. He has other narrowing of the arteries including in the thighs as well as in the left arteries; however, this is not significant enough to be dealt with surgically. This was discussed with the patient. This needs to be monitored and followed up in year's time unless his symptoms change. A lot of the tingling and numbness he has in the lower feet is due to the vascular problem more than anything else.

6-14-10 CMG shows significant change from prior exam in which there was much better accommodation without uninhibited detrusor contractions, a lower pressure detrusor contraction and a much better shape to the voiding curve.

7-22-10 Complex VFR shows total volume voided 128, maximum flow 10, average flow 4. The actual curve shows 3 episodes of flow with interruptions x 2. Post void residual is 161. The evaluator would like to try considering another alpha agonist such as Uroxatral or Rapaflo.

10-20-10 MD., the claimant has an incomplete spinal cord injury at the conus medullaris from a crush injury at work on 4-6-08 with a T12 burst fracture. He voids every 3 1/2 hours and twice a night without incontinence. He is on Flomax, which he was having some dizziness, which have seemed to resolve. His voiding is significantly abnormal in that it is intermittent and low flow. The evaluator changed the claimant from Flomax to Rapaflo.

12-13-10 Peer Review on medications performed by MD., notes the approval for the use of Hydrocodone. Adverse determination for Tamsulosin, Mirtazapine, Lamotrigine, Viagra, Cymbalta, Gabapentin and Flomax.

12-27-10 letter from the claimant to discuss reimbursement of his medications that were denied via Peer Review.

7-22-10 Complex VFR shows total volume voided 128, maximum flow 10, average flow 4. The acute curve shows 3 episodes of flow with interruptions x 2. Post void residual is 161. The claimant is on Flomax at 0.4 mg when he takes 2 he gets dizzy. The evaluator recommended trying another alpha agonist such as Uroxatral or Rapaflo.

1-26-11 MD., performed a Utilization Review. He noted this male sustained a work-related injury on xx/xx/xxxx. The mechanism of injury was a fall that resulted in a crush injury to the spine. The diagnosis was thoracic spine burst fracture at T12. Injuries included spine fracture. Morbidity documented in the chart resulting from this work injury

included depression, mobility impairment requiring a motorized wheelchair, neurogenic bladder, and neuropathic pain. The last clinic examination on 8/19/10 noted neck pain. With respect to the above case, no information that can confirm a decrease in function was provided. The request for an increase to 6 hours per week for a health homemaker aid is given an adverse determination.

1-26-11 Complex CMG notes that when compared to previous study the claimant has a better flow curve which was less interrupted with a slightly increased maximum flow and volume voided. The claimant continues to have an elevation of his bladder pressure during voiding. Recommend the claimant continue on Rapaflo.

3-10-11 MD., the claimant is a male with history of work injury resulting T12 burst fracture and spinal cord injury. He continues having moderate back pain and no leg pain. He has neurogenic bladder. He had been prescribing Hydrocodone. He reports Hydrocodone continues to be helpful. He reports pain level of 6. He continues using electric wheelchair. He states he requires assistance for cleaning, cooking and household chores. He requested he write prescription to restart home health aid services. Objective: Physical: thoracic spine moderate tenderness on palpation around lower thoracic area, lower extremity strength is about 3 out of 5, 2+ patellar reflex bilaterally, no clonus noted in the ankles. Assessment: Status post thoracic spinal cord injury. Plan: Will continue with Hydrocodone. He wrote prescription for 90 which hopefully will last several months he also wrote a prescription to request restarting home health aid services 6 hours per week. Patient understands to be careful with Hydrocodone. He signed a contract not to obtain any narcotics from other physicians. Will have patient return 4 months.

6-23-11 Letter from the claimant: "Please place this note in my file and also forward it along with the doctor's script for 6 hours per week of home health care to the claims adjuster. Since the year of 2004 I have lived alone. My nearest relative is my brother and he is 250 miles away from my home. I have a son and he lives 2000 miles away. I have nobody to help me. This should have been taken into account when a determination was made by some incompetent doctor who reviewed my file. I can't walk. Any competent doctor reviewing my file wouldn't have terminated my home health care, especially if he knew I lived alone. My home health care was terminated at the end of January 2011. I have had the burden to pay someone to come in to clean for me weekly. This is totally unfair and I plan to submit invoices for these expenses incurred by me. Also, since my accident on xx/xx/xxxx I have had to pay for other expenses. I plan to submit a request for reimbursement of these expenses such as maintenance in my home. To name a couple expenses, they are changing light bulbs and an a/c filter which is located in the ceiling. Also, I guess it is assumed that everyone lives in an apartment. At the time of my injury I had and have a house and have to pay someone to maintain my lawn."

6-27-11 MD., performed a Utilization Review. The request for home health aide 6 hours a week is not medically necessary. On xx/xx/xxxx the claimant reported a work-related injury to his back including a T12 burst fracture with spinal cord injury and lower

extremity paralysis, neurogenic bladder, rib fractures and sacral fracture. ODG Guidelines for home health services has not been met. ODG does not allow for home health services for shopping, cleaning, laundry and personal care given by home health aide when this is the only care needed. Review of available medical records indicates that home health services were requested for assistance with cooking, cleaning and household chores. The home health aide for 6 hours a week is not medically necessary and consistent with the referenced guideline.

Novare case management notes.

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

Medical records reflect the claimant sustained T12 burst fracture with canal compromise with paraplegia of L4-L5 with subluxation and questionable sacral fracture, as well as lower extremity paralysis, neurogenic bladder, rib fractures and sacral fracture. Patient required a thoracic fusion from T11 to L2 because of a burst fracture at T12 causing incomplete spinal cord injury. The claimant was treated extensively in an inpatient facility, later transferred to an assisted living facility. Since 2009, the claimant has been living on his own. The claimant continues to have moderate back pain. He continues being modified independent for self-care activities. He requires an electric wheelchair. He has a provider coming in twice a week to do heavy household chores. He continues taking multiple medications including Lorcet for pain. He receives other medications mail-order which include Cymbalta, Flomax and Lamictal. Based on the records provided and the claimant's status post burst T12 fracture and complications from this event, the request for a home health aid 6 hours a week is reasonable and necessary, as this claimant is homebound and limited in the activities he can perform. This would be appropriate for his healthcare needs, such as medications, assistance with his neurogenic bladder, however, not for homemaker services such as like shopping, cleaning, and laundry, and personal care.

ODG-TWC, last update 8-4-11 Occupational Disorders of the Low Back – Home Health Services: Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or “intermittent” basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. These recommendations are consistent with Medicare Guidelines. (CMS, 2004)

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)