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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 2, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

HHA for safety and assistance 10.5 hrs/day for 46 days

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a crush injury while working on xx/xx/xx.

The records start with hospitalization of the patient at on xx/xx/xx. During the hospitalization, the patient underwent x-rays of the left wrist that revealed comminuted fracture of the distal radius with intra-articular extension that had been reduced and stabilized with plate and screws and evidence of ulnar styloid fracture. X-rays of the ribs showed plate and screws over the right anterior 4th, 5th, and 6th ribs and posterior medial fractures of the left 6th and 7th ribs. X-rays of the pelvis showed multi-pelvic fractures with external fixation device and screw passing horizontally from left to right, overlying both sacroiliac (SI) joints and sacrum and plate crossing superior margin of pubic symphysis and fastened with two screws. Magnetic resonance imaging (MRI) of the right shoulder revealed

rotator cuff tendinopathy involving the supraspinatus, infraspinatus and subscapularis tendons, os acromiale with evidence of instability, edema surrounding the coracoclavicular ligaments suggestive of partial acromioclavicular (AC) separation injury, muscle strain or contusion involving the lateral deltoid and moderate subacromial-subdeltoid bursitis. The patient was treated with inpatient rehab and medications. The hospital course was as follows: The patient sustained crush injury while working in xxxxx. His injuries included left orbital fracture with retrobulbar hematoma, sternal fracture, bilateral hemothorax, pneumomediastinum, intraperitoneal bladder rupture and bladder diverticula, grade 3 liver laceration, rectal serosal tear, pelvic ring fracture, L1 corpus fracture, and left distal radius fracture. He underwent rib plating, posterior spinal fusion, pelvic external fixation, open reduction internal fixation (ORIF) of the left distal radius fracture, abdominal re-exploration, abdominal washout, repair of sigmoid serosal injury, placement of Cannica abdominal wall closure device, and abdominal wound VAC placement. He received wound care for his open abdominal wound. His hospital course was complicated by pseudomonas pneumonia and enterococcus faecalis bacteremia for which he was treated with intravenous (IV) cefepime and ciprofloxacin. Once his medical condition had stabilized, he was transferred to xxxxx xxxxx. In rehab, he had pain control with OxyContin ER and Norco. He was also given muscle relaxants for spasms as needed and received chemical anticoagulation and gastrointestinal (GI) prophylaxis. He continued to receive intensive wound care with Medihoney and Mepilex. He was evaluated by nutrition in order to promote good wound healing. On September 6, 2011, he went to the orthopaedic trauma clinic and his pelvic ex-fix was removed. He improved functionally throughout his stay and was discharged on September 7, 2011. The patient was provided with a sliding board, wheelchair plus cushion, drop-arm commode, tub transfer bench, hospital bed and hand-held shower. First call was going provide nursing, physical and occupational therapies and an aide.

On September 7, 2011, the patient was evaluated at for crushing injury, fracture of the pelvis and traumatic open pneumohemothorax. The patient was treated with oxycodone IR, Norco, Colace, Neurontin, Motrin, Robaxin, Senokot, Voltaren gel and Medihoney dressing gel. The patient was recommended home health aide services with a goal of making the patient stable without complications or hospitalization within nine weeks, maintaining the patient's vital signs within prescribed parameters during the nine weeks, the patient and caregiver would verbalize and demonstrate adequate knowledge of disease process/management including medications, diet, safety and signs and symptoms to report within nine weeks and oxygen saturation will remain greater than 90% for nine weeks. The request for 10 hours a day home health aid (HHA) was authorized.

The patient received HHA from November 2011 through January 2012 consisting of 35 visits. Per utilization review referral form, the patient had sustained multiple traumas and was diagnosed with crushing injury, fracture of pelvis, traumatic pneumothorax, multiple trauma, multiple fractures and bladder rupture. He was treated by.

Per utilization review dated January 12, 2012, the evaluator noted the following treatment history: The patient was status post pelvic external fixation with removal of pelvic external fixation on September 6, 2011. The patient had attended aquatic therapy with improvement, 16 sessions of physical therapy with improvement, other health services and home exercise program (HEP). The request for HHA for safety and assistance 10.5 hours a day for three months was denied with the following rationale: *“This is a request for home health services, as per latest medical report dated December 15, 2011, the patient was noted to have been attending physical therapy, with improvement in balance, flexibility exercise, body mechanics, cardiovascular exercises, strength and gait without any device, exercise tolerance, and functional tasks. He was noted however, to be limited with strength in both lower extremities in all planes, exercise tolerance and functional mobility tasks including ascending and descending stairs. The specific tasks to be performed by the HHA were not specified in the submitted records. It is noted that the patient had received home health services from September 7, 2011, to October 7, 2011. However, the personal care flow sheets provided included tasks such as laundry and housekeeping activities which are not considered as medical treatment. Hence the medical necessity performed health services cannot be determined at this point.”*

Per nurse note dated January 17, 2012, the patient showed weakness, abnormal gait and balance, abnormal strength and endurance and frequent pain primarily in the right shoulder. The assessment was that the patient needed continued CNA care as he was able to ambulate short distances but tired easily and needed some assistance with activities of daily living (ADL) and was unable to complete housekeeping tasks. He had developed right shoulder pain and was being evaluated for possible rotator cuff injury. He needed someone at his meals and for safety needs.

On January 30, 2012, evaluated the patient for right shoulder weakness. noted that the patient had rib fractures, pelvic fracture and wrist fracture and had some pain in his shoulder with weakness. He had at least 12 sessions of PT without any significant improvement and rated pain as 6/10 at best and 6/10 at its worst. The MRI of the shoulder had revealed some rotator cuff tendinopathy and os acromiale with some signal and possible AC joint injury. Examination showed decreased ROM, weakness and some pain with O'Brien's testing, pain and weakness to Speeds testing and decreased strength. obtained x-rays that showed presence of possible previous AC joint injury and questionable injury to the supraclavicular nerve. He assessed right shoulder weakness with concern for suprascapular nerve injury and possible superior labral injury. recommended electromyography/nerve conduction velocity (EMG/NCV) to specifically look at the suprascapular nerve and ordered MR arthrogram of the shoulder.

Per reconsideration review dated February 9, 2012, the appeal for HHA for safety and assistance 10.5 hours a day for 46 days was denied with the following rationale: *“This is an appeal request for HHA for safety and assistance 10.5 hours a day for 46 days. As per medical report dated December 15, 2011, the patient was noted to have been attending PT with improvement in balance, flexibility exercise, body mechanics, cardiovascular exercises, strength and gait*

without any device, exercise tolerance, and functional tasks. He was noted however, to be limited with strength in the lower extremities in all planes, exercise tolerance and functional mobility tasks including ascending and descending stairs. Upon review of the report, the specific tasks to be performed by the HHA were not specified in the submitted records. It is noted that the patient had received home health services from September 7, 2011, to January 6, 2012. However, the personal care flow sheets provided included tasks such as laundry and housekeeping activities which are not considered as medical treatment. With this, the previous non-certification of the request is upheld.”

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

Although the patient does demonstrate deficiencies in some of his ADLs no medical is reported as needed, only non medical. Specific tasks were not mentioned, only the inability to perform housekeeping tasks was referred to. ODG specifically states “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.” Therefore, since no medical treatment is defined in the records the decision is upheld.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES