

IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

12/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: continued approval for home health care, spinal cord injury: four hours per day, seven days per week for dates of service 10/24/13 thru 1/24/14 at Home Health Services as requested by Dr.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified PM&R; Board Certified Pain Medicine

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Home health care notes dated 08/31/13 – 09/06/13
Clinical note addendum dated 02/25/13
Letter of medical necessity dated 04/12/13
Required medical exam dated 04/30/13
Mobility evaluation note dated 06/12/13
Operative note dated 07/16/13
Clinical note dated 08/22/13
Clinical note dated 09/23/13
Adverse determinations dated 05/15/13 & 10/21/13

Letters of appeal dated 10/29/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury on xx/xx/xx when she was a passenger in a vehicle that had lost control and fell over a cliff approximately 100 feet. The clinical note dated 02/25/13 indicates the patient unable to move her lower extremities with a complete loss of sensation. The note does mention the patient having undergone a spinal stabilization surgery at T10 through T12. The note further mentions the patient having undergone a pain pump implantation with subsequent refills. The clinical note dated 04/12/13 indicates the patient having undergone an implantation of a pain pump on 07/01/11. The note mentions the patient requiring assistance with nearly all activities of daily living to include dressing, transferring, eating, and wheelchair mobility. The RME dated 04/30/13 indicates the patient continuing with loss of sensation with weakness in the lower extremities. The patient did have complaints of a burning type sensation as well as pins and needles. The note mentions the patient utilizing a home health aide for all functional assistance. The mobility evaluation dated 09/03/13 indicates the patient being recommended for an ultra-light manual wheelchair. The operative report dated 07/12/13 indicates the patient undergoing a left lower extremity wound debridement. The wound measured 6 x 2.5cm. The patient was noted to have undergone a split skin graft measuring 60 square centimeters. The clinical note dated 08/22/13 indicates the patient utilizing an extensive list of pharmacological interventions for ongoing pain relief. The patient was noted to have significant findings of clonus in the lower extremities. The clinical note dated 09/23/13 indicates the patient continuing with ongoing pump refills of Fentanyl 1.5mg. The patient rated her pain as 6/10.

The utilization review dated 05/15/13 resulted in a denial for home health services secondary to the patient requiring essentially constant care.

The utilization review dated 10/21/13 resulted in a denial for home health services as no information was submitted regarding the ongoing need for medical care.

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

The documentation submitted for review elaborates the patient having sustained a low back injury resulting in a loss of sensation in the lower extremities. Home health care would be indicated provided the patient meets specific criteria to include the need for intermittent or part time care and the patient is noted to require medical treatment despite being home bound. According to the documentation submitted for review, the patient presents as needing constant care to include with all transfers, all activities of daily living, as well as bladder and bowel control. According to the submitted clinical documentation it appears the patient is in need of constant care to include for all functional assistance. Thus, the patient's needs exceed recommendations. As such, it is the opinion of this reviewer that the request for continued home health care 4 hours per day, 7 days per week from 10/24/13 through

01/24/14 is not recommended as medically necessary.

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

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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)