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Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE – WC

June 29, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

24 hours 7 days a week home health (CNA)

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

Board Certified Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

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

X Partially Overturned (Agree in part/Disagree in part)

Medical documentation **partially supports** the medical necessity of the health care services in dispute.

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:

TDI

- Utilization reviews (05/06/13, 05/16/13)

- Utilization reviews (10/17/12, 05/06/13, 05/16/13)
- Office visits (02/19/13 – 05/09/13)
- Nursecare (02/28/13 – 04/21/13)
- Diagnostics (04/16/13)

Scanned documents

- Diagnostics (01/19/04 – 03/02/04)
- Office visits (02/02/04 – 11/02/04)

- PT (02/20/04 - 10/22/04)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had a work-related injury on xx/xx/xx, to his head and neck. However, the details of mechanism of injury are not provided.

On January 19, 2004, magnetic resonance imaging (MRI) of the lumbar spine showed: (1) At L5-S1, mild disc desiccation, minimal 2-mm annular bulging without focal lateralizing soft disc protrusion, mild facet hypertrophy without bony foraminal compromise or cross-sectional narrowing of the canal. (2) At L4-L5, evidence of mild disc desiccation. There was minimal approximately 2-mm broad-based bulge. There was a small focal area of signal in the midline posteriorly probably reflecting a small annular tear. There was slight facet and mild ligamentum flavum hypertrophy without bony foraminal compromises or cross-sectional narrowing of the canal. (3) At L3-L4, mild narrowing of the disc space along with disc desiccation. There was minimal posterolateral annular bulging on each side without focal lateralizing soft disc protrusion. Mild disc space narrowing and disc desiccation without evidence of disc protrusion. (4) At L1-L2, mild narrowing and disc desiccation. There was a mild approximate 2-mm asymmetric left bulge/protrusion producing slight focal effacement of the anterolateral sac on the left side. (5) T11-T12 was at the very superior edge of the field and not optimally seen. There was suggestion that there was some mild posterolateral bulging without obvious focal soft disc herniation.

On January 21, 2004, MRI of the cervical spine showed: (1) At C6-C7, minimal annular bulging without focal lateralizing soft tissue protrusion. (2) At C5-C6, narrowing of the disc space, mild 2-3 mm broad-based uncinete spur, possibility of a mild soft tissue disc bulge, but that was primarily bony in nature. The findings produced mild anteroposterior diameter narrowing of the canal to approximately 8 mm. (3) At C4-C5, evidence of a previous anterior cervical fusion. There was mild anteroposterior diameter narrowing of the canal measuring roughly 8 mm. (4) At C3-C4, perhaps minimal uncinete ridging, but was otherwise unremarkable. This report is incomplete.

Per therapy discharge summary dated January 30, 2004, the patient had attended therapy from October 15, 2003, through January 30, 2004.

On February 2, 2004, the patient was evaluated. He had cervical stenosis identified and underwent surgery on July 18, 2003, for decompression and fusion. Provisional diagnosis was tetraparesis (spastic) with Brown-Sequard and hypertension. From February 3, 2004, through February 13, 2004, the patient was treated at the Baylor Institute of Rehabilitation.

Per PT discharge summary note dated February 13, 2004, the patient was recommended outpatient PT/occupational therapy together. He had not progressed functionally in the short period during treatment and also had not had significant gain to justify staying.

On February 20, 2004, the patient was evaluated. He was recommended strengthening exercises, range of motion (ROM)/flexibility exercises and aquatic exercises for cervical spine.

On March 2, 2004 evaluated the patient for severe low back pain that was problematic in the last month and was producing right lower extremity numbness and tingling and loss of sensation. It was noted that following the C5 cervical cord injury, the patient had a tetraplegia. His right lower extremity changes were worse with prolonged sitting and pressure. History was remarkable for the quadriplegia that occurred after the July 2002 event. The patient had an acute care admission after the July 2002 event to rule out a cerebrovascular accident (CVA). He eventually became slurred with respect to speech and lost all mobility without sensory loss in his limbs. He was then admitted where workup was performed. He was then eventually taken to surgery secondary to a herniated disc with subsequent spinal stenosis. Since that point, he had been through the Baylor Institute of Rehabilitation program and had been released on October 6, 2003, to a home exercise program (HEP). He subsequently had another admission to for two weeks and then back for outpatient therapy. Presently, he had a hospital bed and custom wheelchair. diagnosed low back pain with right lower extremity pain, paresthesias and spasms suspicious for either a radicular component, spinal stenotic component versus facet mediated low back pain. felt that the patient possibly had a congenital spinal stenosis of the cervical spine and hence lumbar spine imaging study was prudent. He recommended obtaining nerve conduction study and electromyography (EMG) if MRI was suspicious. He would try to get a lumbosacral corset in place for the patient for further lumbar spine support.

On March 2, 2004, MRI of the lumbar spine showed: (1) At T10-T11, there was a desiccation of the intervertebral discs, but no focal herniation present. (2) At T11-T12, there was a left paramedian herniation of the intervertebral disc at T11-T12. A portion of the disc actually protruded into the inferior aspect of the left neural foramen as best visualized on the sagittal images. That did not produce spinal cord compression of the conus. (3) L1-At L2, the spinal canal measured 15 mm in anteroposterior diameter and 23 mm in transverse dimension at L2. The neural foramina at L2 were widely patent and showed no narrowing. At L4, the spinal canal measured 18 mm in the anteroposterior dimension and 27 mm in the transverse dimension. The inferior aspects of the neural foramina were narrowed bilaterally at L4-L5 secondary to apophyseal joint hypertrophy. (4) At L5, the spinal canal measured 19 mm in the anteroposterior dimension and 24 mm in transverse dimension. (5) At S1, the spinal canal measured approximately 20 mm in anteroposterior dimension and 20 mm in transverse dimension. (6) At S2, the spinal canal measured approximately 12 mm in the anteroposterior dimension and 13 mm in transverse dimension.

On March 23, 2004, the patient underwent a PT evaluation. He was recommended 12 sessions of PT/OT in four weeks and was prescribed splint fabrication.

Per the attending physician's statement of disability dated March 24, 2004, the patient was totally disabled for his regular occupation. Diagnosis was cervical spinal stenosis, quadriplegia, vocal cord paralysis and back pain. Mental condition was depression with suicidal ideation

On March 31, 2004, noted the patient was receiving treatment at a rehab facility on a twice-a-day basis. He complained of back pain, some numbness in the lower extremities and over the ulnar territory of the right upper extremity and some blood in stool and with a problem of constipation since the injury. diagnosed severe cervical myelopathy due to an on-the-job injury, some respiratory compromise as a consequence to the myelopathy, weak vocal cords that had required surgical repair but was still chronic, low back pain from prolonged sitting in a chair, probable right ulnar neuropathy from resting the elbow against the wheelchair arm, blood in the stool probably due to constipation and numbness episodes in the lower extremities of uncertain etiology. opined that the patient would benefit from more rehabilitation.

From April 14, 2004, through September 27, 2004, evaluated the patient and recommended continuing physical therapy (PT). He felt that the patient might require further additional electric wheelchairs or adjustments made to the present one that he had. The patient might develop bed sores or compression neuropathy from not being able to ambulate and being primarily in a seated position. He required special bed equipment. Given these considerations, it was impossible to determine the patient's future lifelong expense, but it would be tremendous and could total hundreds of thousands of dollars.

Per PT discharge summary dated October 22, 2004, the patient had attended eight sessions of PT consisting of neuromuscular re-education and therapeutic exercises.

On November 2, 2004, stopped Zanaflex and prescribed Vicodin, baclofen and Lexapro.

On February 4, 2009, authorized supplies including bedside commodes, shower chair and electric wheelchair.

Per utilization review dated October 6, 2012, the request for bath/shower chair was authorized.

Per utilization review dated October 17, 2012, the request for home health aide was authorized.

On February 19, 2013, the patient presented to with a request for need of CNA assistance. In response to the patient's request, asked an authorization to consider for CNA 24-hour coverage.

From February 28, 2013, through April 21, 2013, the patient underwent several nurse visits.

On April 16, 2013, performed an electromyography/nerve conduction velocity (EMG/NCV) that supported mostly a severe left femoral neuropathy. It did not completely exclude the possibility of a lumbar plexopathy or L3-L4 radiculopathy.

Per utilization review dated May 6, 2013, the request for home health aide 24 hours a day for seven days a week from March 1, 2013, through June 30, 2013, was denied based on the following rationale: *“There was no indication that the claimant is receiving medical or skilled healthcare from the individuals who are staying with him 24 hours a day for seven days a week. In this case, his current caregivers are providing primarily homemaker services. Home health care is not approved when there is only a need for tasks like shopping, bathing and daily chores. He currently is receiving non-skilled custodial care. Thus, there is no necessity for the requested home health care. Therefore, a home health aide 24 hours a day for seven days a week from March 1, 2013, through June 30, 2013, is not necessary or appropriate.”*

On May 9, 2013, the patient presented. The patient had confidence that CNA's were much more reliable. The CNA were consistently able to transport him better, help to prevent bed sores better and to resolve his frequent problems with bowel impactions much better than companion sitters. Over the last few weeks, he complained of nocturnal episodes of right upper extremity numbness from the shoulder down. stated he believed that a CNA was a more qualified and the patient should have a CNA.

Per reconsideration review dated May 16, 2013, the appeal for home health CNA 24 hours a day for seven days a week was denied based on the following rationale: *“A CNA home health for an hour or so per day to help the claimant with a bowel program, which was a medical and preventive necessity. The rest of the day can be managed with an unskilled aide. I did propose this to the treating physician and he did not disagree.”*

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

Twenty –four hour per day, seven days a week CAN care is not necessary although one to two hours per day for bowel care is. The other hours can be provided by unskilled aides. Therefore, the decision is partially overturned to allow skilled care one to two hours per day for bowel care which should be managed by skilled aide and would be medically necessary.

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

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES