

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

June 20, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Home Health Aide (2 x week x 4 wk) or 8 visits

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

American Osteopathic Board of Orthopedic Surgery

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

xxxxx, preoperative and postoperative diagnosis: Right hip hematoma, status post total hip arthroplasty. Procedure: Revision hip arthroplasty of both femoral and acetabular components.

xxxxx, preoperative and postoperative diagnosis: Right hip hematoma, status post total hip arthroplasty, arterial bleeding from posteromedial femoral circumflex vessel. Procedure: Revision hip arthroplasty of both femoral and acetabular components.

11-3-11, preoperative and postoperative diagnosis: Infected right total hip. Procedure: Incision and drainage of right hip with exchange of femoral and acetabular components. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

11-17-11, The claimant was taken off work from xx/xx/xx through xx/xx/xx.

11-23-11, The claimant was taken off work from xx/xx/xx through xx/xx/xx.

11-25-11, The claimant was taken off work from xx/xx/xx through xx/xx/xx.

12-7-11, The claimant was taken off work from xx/xx/xx through xx/xx/xx.

12-8-11 Lab work performed.

12-22-11 Lab work performed.

12-22-11, the claimant is a gentleman who underwent his initial surgery for right hip fracture back in xxxxx. About a month later he presented with a draining hematoma. The evaluator was on-call and the initial surgery was for his primary total hip. They did an incision and drainage procedure on him as he had a very large hematoma that was complicated by infection with *Enterococcus faecalis*. He was treated with IV ampicillin that was sensitive after a thorough washout and exchange of components. That did not improve his quality of drainage or amount of drainage from the hip wound. He was felt to have a failed suppressive antibiotic procedure, therefore a revision procedure was chosen. A staged revision was elected to be performed with a Prostalac antibiotic impregnated spacer and this was inserted on 12/07/11. He was doing well and discharged with some mild wound drainage to the skilled nursing facility on daptomycin which his cultures had grown at that point sensitive to Staph and resistant *Staphylococcus epidermidis*. The claimant also had *Enterococcus* from the previous culture. These were felt to be treated accurately with the daptomycin. The claimant was seen routinely and followed in his office today for a wound check. He had developed abscess posterior to his hip incision and the posterior skin flap was indurated and drained of frank pus. The claimant is being admitted for incision and drainage of this right abscess. Plan: The claimant is admitted for an incision and drainage procedure and likely to

continue IV antibiotics and possible surgical washouts and packing of this right hip infected wound.

12-22-11, preoperative and postoperative diagnosis: Right hip abscess. Procedure: Right hip incision and drainage.

1-4-12 Lab work performed.

1-5-12 X-ray of the right hip, showed postoperative changes are present involving the right hip with extensive soft tissue heterotopic calcification. No frank bony destruction is noted. Acetabular component may be impregnated. Moderate vascular calcification is incidentally noted. Overall appearance is stable compared to prior.

1-6-12, the claimant returns for a postoperative visit after undergoing prostilac prosthesis of the left hip. The claimant has no unusual complaints. The claimant denies fever, chills, excessive drainage from the wound, and changes in sensation or strength. The claimant is taking pain medication and is partial weight bearing with a walker. Assessment: Other postsurgical states; other post procedural status; other. Plan: Continue outpatient wound care. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

1-13-12, the claimant returns for a postoperative visit after undergoing prostilac prosthesis of the left hip. The claimant has no unusual complaints. The claimant denies fever, chills, excessive drainage from the wound, and changes in sensation or strength. The claimant is taking pain medication and is partial weight bearing with a walker. Assessment: Other postsurgical states; other post procedural status; other. Plan: Continue outpatient wound care. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

1-19-12 X-ray of the right hip, showed satisfactory appearance of the right hip prosthesis. No change from previous.

Follow-up visit on 1-20-12 notes the claimant is to continue outpatient wound care.

Follow-up visit on 2-3-12, 2-10-12 notes the claimant is to continue outpatient wound care. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

Health Insurance Claim Form.

2-22-12 Lab work performed.

2-23-12 X-ray of the right hip showed postoperative right hip.

2-23-12 Lab work performed.

Follow-up visit on 2-24-12 notes the claimant is to continue outpatient wound care. Continue Clindamycin. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

3-7-12 Lab work performed.

Follow-up visit on 3-9-12 notes the claimant is to continue Clindamycin. Hip aspiration ordered. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

3-30-12 Lab work performed.

3-30-12, the claimant presents today for an arthrogram and aspiration of the right hip at the ACC. Informed consent was obtained.

4-3-12, the claimant is a male who presents for evaluation of moderate to severe right hip pain. His last operative procedure was 12/22/2011. His wound has healed and his prostilac spacer is still functioning. His hip aspiration last week was negative and his most recent lab work is normal. He is now a candidate for his staged total hip revision. He is still on his suppressive Clindamycin. The claimant has no additional complaints. The claimant denies radicular symptoms, sensory changes, and weakness. Assessment: Painful endoprosthesis, right osteolysis THR. Plan: RTC after surgery. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

4-11-12, preoperative and postoperative diagnosis: Right hip aspiration under fluoro. Procedure: Right hip aspiration.

4-19-12 Lab work performed.

5-1-12 Lab work performed.

5-6-12 Lab work performed.

5-15-12, the claimant is a male who presents for evaluation of moderate to severe right hip pain. His last operative procedure was 12/22/2011. His wound has healed and his prostilac spacer is still functioning. His hip aspiration was negative and his most recent lab work is normal. He is now a candidate for his staged total hip revision. He is still on his suppressive Clindamycin. Assessment: Right Painful endoprosthesis, right osteolysis THR. Plan: Schedule surgery.

5-15-12 Lab work performed.

Fax coversheet to; ref: Pre-admission test results.

5-16-12, preoperative and postoperative diagnosis: Staged revision of right total hip. Procedure: Revision hip arthroplasty. Removal of prosthetic implant.

5-29-12 X-ray of the right hip, showed there are no fractures present. There is no arthritis present. There are components of the hip which are well fixed and well aligned. There are no destructive lesions.

5-29-12, the claimant returns for a postoperative visit after undergoing a revision THA on 3/16/2012. He feels well, he still has some serosanguinous drainage. He is on his oxacillin infusion for the one culture that grew MSSE. Assessment: Right other postsurgical states; other post procedural status; other, hip replacement, right osteolysis THR. Plan: The claimant will return on Thursday for a wound check, if drainage persists may need wound care or VAC.

5-29-12 Lab work performed.

5-31-12, the claimant returns for a postoperative visit after undergoing a revision THA on 3/16/2012. He feels well, he still has some serosanguinous drainage. His ESR was 20 and INR 1.5. He is on his oxacillin infusion for the one culture that grew MSSE. His original culture grew MRSA so I am going to restart Clindamycin to cover that as well. Assessment: Right other postsurgical states; other post procedural status; other, hip replacement, right osteolysis THR. Plan: Wound VAC and wound care ordered. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

6-14-12, the claimant returns for a postoperative visit after undergoing a revision THA on 3/16/2012. He feels well, he still has some serosanguinous drainage that is being managed with a wound VAC. He has had his PICC line replaced three times now. There has been some difficulty with compliance with his meds and PT. Assessment: Right other postsurgical states; other post procedural status; other, hip replacement, right osteolysis THR. Plan: Continue Clindamycin. The evaluator will see him in wound care tomorrow to assess his incision. Continue IV oxacillin. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

6-15-12 Lab work performed.

6-17-12 Lab work performed.

6-26-12, the claimant returns for a postoperative visit after undergoing a revision THA on 5/16/2012. He feels well, he still has some serosanguinous drainage that persists but is diminishing. He has been confused or non compliant with his VAC. He asked him directly about his VAC. He replied "It's on", however the hose is not connected. I am convinced he knows what it should be connected to, but there may be some conflicting instructions here, so the evaluator called wound care. Apparently, do to persist issues, they instructed him to stop the VAC and are now doing daily dressing changes. He had his dressing changed yesterday. The evaluator

explained to the claimant that his hip is likely still infected as it has been draining for over 5 weeks. The evaluator has told him the best they can hope for now is a suppressible infection. However if his symptoms should persist or worsen he may require a resection arthroplasty. The evaluator is going to continue his IV antibiotics for 3 more weeks in hopes that his wound will stop draining. His recent x-rays show a well aligned a well fixed prosthesis. Assessment: Right other postsurgical states; other post procedural status; other, hip replacement, right osteolysis THR. Plan: Continue Clindamycin. The evaluator will see him in wound care tomorrow to assess his incision. Continue IV oxacillin. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

7-17-12, the claimant returns for a postoperative visit after undergoing a revision THA on 5/16/2012. He feels well. He has tried to be more compliant with his wound VAC. The evaluator spoke and she and the evaluator both agree he is improving. He still has some serrous drainage. He is slow to mobilize with PT. Recent x-rays reviewed and his implant is doing well. Assessment: Right other postsurgical states; other post procedural status; other, hip replacement, right osteolysis THR. Plan: Continue Clindamycin. Continue IV oxacillin until labs return. If labs improved may stop oxacillin, but continue clinamycin. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

7-18-12 Lab work performed.

8-6-12 X-ray of the right hip showed postoperative right hip.

Physical Therapy on 8-7-12, 8-21-12.

8-7-12, the claimant returns for a postoperative visit after undergoing a revision THA on 5/16/2012. He feels well. He walked into the office today which hasn't happened in over 9 months. He has completed his wound VAC. He is on Clindamycin. Assessment: Right other postsurgical states; other post procedural status; other, hip replacement, right osteolysis THR. Plan: Continue Clindamycin. Continue WBAT R LE. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

Follow-up visit on 8-21-12 notes the claimant was continued with Clindamycin. Continue WBAT R LE. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

8-22-12 Lab work performed.

9-10-12 Lab work performed.

Follow-up visit on 9-11-12, 10-11-12 notes the claimant was continued with Clindamycin. Continue WBAT R LE. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

10-8-12 Lab work performed.

10-12-12 Lab work performed.

11-1-12 Physical Therapy Evaluation.

Follow-up visit on 11-19-12 notes the claimant was continued with Clindamycin. Continue WBAT R LE. The evaluator ordered CT scan of hip. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

Physical Therapy on 11-19-12.

11-26-12, the claimant presented to the ER on xx/xx/xx with a new area of fluctuance that developed in his right hip wound. It was aspirated sterily in the ER by the evaluator, personally. It has grown enterococcus fecalis which is pan sensitive. This is the same organism that he grew initially. He was on oral clindamycin. Vancomycin IV has been started. He had his CT which show a likely deep infection of his right THA. He has failed suppressive antibiotics and will likely require a repeat staged revision or a resection arthroplasty. Assessment: Right hip replacement, right chronic infected THR. Plan: The evaluator spent almost an hour today with the claimant. The evaluator explained his situation in detail, and he expressed understanding. Basically all the efforts in eradicating his hip infection have been unsuccessful. He is faced with repeating the same scenario of a staged revision or a resection arthroplasty. He wants to salvage his hip if possible. He is aware that it may not be possible. At this point the evaluator recommended a hip specialist in a tertiary care center and a ID specialist. His wound is draining currently so time is a factor and these referrals should be expedited. The evaluator has spoken and she or her partner is willing to evaluate the claimant. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

11-29-12 Fax coversheet to: trough lab

11-29-12 Lab work performed.

12-4-12, the claimant presented to the ER on xx/xx/xx with a new area of fluctuance that developed in his right hip wound. It was aspirated sterily in the ER by him, personally. It has grown enterococcus fecalis which is pan sensitive. This is the same organism that he grew initially. Vancomycin IV is controlling his infection. He has failed suppressive antibiotics and will likely require a repeat staged revision or a resection arthroplasty. He has an appointment on 12/7/2012. Hopefully, with a repeat staged revision and ID specialist he can have a functional hip. He may still

require a resection arthroplasty. Assessment: Right hip replacement, right chronic infected THR. Plan: The evaluator has explained his situation in detail, and he expressed understanding. Basically all the efforts in eradicating his hip infection have been unsuccessful. He is faced with repeating the same scenario of a staged revision or a resection arthroplasty. He wants to salvage his hip if possible. He is aware that it may not be possible. At this point the evaluator recommended a hip specialist in a tertiary care center and a ID specialist. He has an appointment on Monday.

Follow-up visit on 12-21-12 notes the evaluator explained his situation in detail, and he expressed understanding. Basically all the efforts in eradicating his hip infection have been unsuccessful. He is faced with repeating the same scenario of a staged revision or a resection arthroplasty. He wants to salvage his hip if possible. He is aware that it may not be possible. At this point the evaluator still recommend he continue to follow up with hip specialist in a tertiary care center and a ID specialist. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

1-17-13 Cancellation of designated doctor examination.

2-1-13, the claimant saw for his chronic hip infection due enterococcus fecalis. He was changed to rifampin and bactrim po. His wound has been dry since the last visit. He is home now and functioning ok. He seems to be doing better. He may still require a staged revision or resection arthroplasty. The evaluator still thinks an ID consult would be very helpful. X-ray of the AP pelvis and lateral of the right hip showed there are no fractures present. There is no arthritis present. There are components of the hip which are well fixed and well aligned. There are lesions present but no destructive lesions noted. He has HO and possibly involucrum around his prosthesis. Assessment: Right Hip replacement, right chronic infected THR. Plan: The evaluator ordered x-ray of the pelvis. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

2-1-13 Lab work performed.

Follow-up visit on 4-5-13 notes the evaluator ordered x-ray of the pelvis.

4-12-13, performed a Designated Doctor Evaluation. He certified the claimant had not reached MMI and estimated 7-12-13 as the date of MMI. The claimant is to undergone further physical therapy and possible infectious disease input. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

Follow-up visit on 4-24-13 notes the evaluator ordered bone scan. The evaluator will check a gallium scan to see if there is any increasing infection or loosening of his prosthesis. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

Fax coversheet to: treating physician: ref: Designated Doctor Outsourcing.

5-6-13 Gallium scan showed abnormal periprosthetic gallium uptake surrounding the right hip prosthesis. Recommend bone scan for combined bone scan-gallium scan correlation.

5-16-13 Lab work performed.

Follow-up visit on 5-16-13 notes the claimant will follow-up in three months with repeat labs and x-rays. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

5-17-13 Lab work performed.

8-16-13, the claimant is stable. He is still on suppression antibiotics. Assessment: Right Chronic infected THR. Plan: Hip precautions reviewed.

8-28-13 Physical Therapy Evaluation.

10-15-13 Physical Therapy Discharge.

11-26-13 Fax coversheet ref: Rehab

Fax coversheet to CLAIMS EVAL; ref: IRO.

3-13-14, the claimant returns for follow-up regarding his chronically infected right total hip arthroplasty. He currently remains on Augmentin 875 mg twice daily for chronic suppression in an effort to prevent reactivation of suspected infection involving his right total hip arthroplasty. He has been compliant with his antibiotic therapy and states that he has not had any side effects from the Augmentin. He has not experienced any problems with abdominal pain or diarrhea. He states that there has been no swelling or erythema, nor any drainage from the right hip surgical incision. He continues to have a moderate amount of pain and is still requiring use of a walker for ambulation. Assessment: Chronically infected right total hip arthroplasty, stable and continuing to do well on oral Augmentin. Cultures from surgical debridement procedures on several occasions did recover oxacillin susceptible Staphylococcus aureus, oxacillin susceptible Staphylococcus epidermidis, and ampicillin susceptible enterococcus. Given no signs of any recrudescence infection, the evaluator thinks it would be reasonable to reduce his Augmentin dose at this point to 500 mg twice a day. His ambulatory status is still quite limited as a result of his ongoing pain. The evaluator discussed the fact that his chronic pain and is ambulatory status are not likely to improve much beyond his current baseline, and if he wishes to more aggressively pursue some attempt to return to his previous more functional status then he may need to consider the possibility of another revision arthroplasty. Plan: Decrease Augmentin 2 500 mg twice daily. The claimant may need to consider the possibility of another revision arthroplasty if he wants to

pursue efforts to try to reduce or resolve his current level of pain and return to his previous more functional status. Although the evaluator is optimistic that he can successfully suppress any residual infection involving his current right total hip arthroplasty, it is not likely that any medical treatment will improve his pain or ambulatory status. Schedule next follow-up here in 6 months.

3-27-14, the evaluator noted that is his patient who he has treated since 10/2011. His initial work related injury was a fall that fractured his right hip in xx/xxxx. His index surgery was complicated by a hematoma and infection. After multiple procedures to address and eradicate his infection, Mr. still has an infected hip replacement that is a significant disability to him. He can only ambulate with a walker and he cannot climb stairs. Unfortunately, he has a two story condo and his shower is up stairs. He would benefit from any home assistance in completing his ADL's and personal hygiene. Please contact his office with any questions.

4-7-14 Lab work performed.

4-10-14 Fax coversheet to: Pre-Auth; need auth for a whole body bone scan.

4-10-14, the claimant returns for a postoperative visit after undergoing revision THA of the right hip 5-16-12. He is stable. He is still on suppressive amoxicillin. He has had no drainage. He complains of moderate pain, and uses a walker full time and cannot climb stairs. Assessment: Right Chronic Infected THR. Plan: The evaluator order bone scan and physical therapy. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

4-16-14 Bone scan, showed extensive abnormal uptake about the right hip. Degenerative uptake both knees.

Home Health Care on 4-14-14: Called the claimant to schedule eval.

Home Health Care on 4-17-14: Call to the claimant's home, he states he is busy today and unavailable for assessment for home care assistance.

Home Health Care on 4-17-14: 2nd call to the claimant to see if he has time for evaluation later today.

Home Health Care on 4-22-14.

4-25-14, the claimant returned for follow-up. The claimant has had no drainage. He complains of moderate pain, and uses a walker full time and cannot climb stairs. His bone scan was completed and showed increased uptake in his right hip consistent with his chronic infection. He is on his suppressive antibiotics. Assessment: Right Chronic Infected THR. Plan: The evaluator ordered physical therapy. The claimant was taken off work from xx/xx/xx through xx/xx/xx.

Home Health Care on 4-30-14: The claimant was evaluated for home health physical therapy necessity.

5-12-14 Fax coversheet to: Claims; ref: Request approval for aide 2x wk.

5-16-14 Utilization Review Determination: The authorization request for Home health aide (2wk4) or 8 visits, was reviewed by a Physician Advisor, Occupational Medicine, Urology, Preventive Medicine: Occupational Medicine, Urology, who determined that it does not meet medical necessity guidelines.

5-23-14 Utilization Review Determination: An appeal of the UR denial determination issued on 5/15/2014, for the treatment requested, was received on 5/19/2014. It was determined that it does not meet medical necessity guidelines.

5-27-14 Request form: Request for a review by an independent review organization.

6-4-14 Notice of assignment to independent review organization.

6-4-14 Fax coversheet IRO notice of assignment (IRO).

Provider that received the denial:

Fax coversheet to: IRO HWCN Division, IRO Filing; ref: IRO.

Independent Review Portal: IRO Request Details.

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

Medical records reflect a claimant with Right Chronic Infected THR. It is noted the claimant ambulates with a walker, but he is not housebound. ODG reflects that home health aid is reasonable if it is to provide medical treatment to a homebound patient, but not for shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The primary reason for this request is for homemaker responsibilities. Therefore, the request for Home Health Aide (2 x week x 4 wk) or 8 visits is not reasonable or medically necessary.

ODG 2014 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. Home health skilled nursing is recommended for wound care or IV antibiotic administration.

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)**