Medical Assessments, Inc.

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March 20, 2018 Amended June 22, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
PT 2x9 (18 visits), Home Health Aide for 24 hours/a day, 7 days/wk for 9 weeks (1512) hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is a Board Certified Orthopedic Surgeon with over 15 years of experience

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

PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant is a XXXX requesting Home Health Aide for 24 hrs/day, 7 days/wk x 9 weeks (1512 hours)

XXXX: Progress notes by **XXXX**. The claimant XX right distal femoral replacement as a second stage reimplantation following a chronically injected right total knee arthroplasty. This was a salvage procedure to avoid amputation. XXXX has been wearing a drop lock hinge brace for the past 3-4 months. Despite use of this brace XXXX continues to have instability resulting in several falls. XXXX has been working with pt. XXXX has lost a significant amount of weight. As a result of instability XXXX continues to use a wheelchair most of the time. PE reveals XXXX is able to stand and bear weight but XXXX feels unstable. XXXX ROM is from slight hyperextension to 95. XXXX does have laxity to stressing. XXXX edema is instability. Treatment plan is for drop lock knee brace, possible revision surgery, PT, acupuncture, surgery and medications.

XXXX: UR performed by **XXXX**. Rationale for denial: The claimant has had multiple rounds of therapy. There is no comment regarding benefit. The documentation notes rehab potential is poor. There is no body part listed or rationale provided as to what specific therapy is meant to address. Non-certification.

XXXX: UR performed by **XXXX**. Rationale for denial: The claimant has had multiple round of therapy to date. There is no body part listed or rationale provided as to what specific functional deficit therapy is meant to address. In regards to home health, the documentation is vague on deficits which made this necessary. The claimant appears to have primary caregiver. Diagnosis includes right distal femoral replacement with continued right knee instability. No body part listed or rationale provided as to what specific functional deficit therapy is meant to address. Decision: upheld

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS,

FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for additional physical therapy is denied. The request for a home health aide is approved.

This patient is a XXXX who underwent a distal femoral replacement XX years ago, following an infected total knee replacement. XXXX current prosthesis has instability. XXXX knee hyperextends and only flexes to 95 degrees. There is shortening of the extremity. The treating physician has recommended modification of the knee brace, with the possibility for additional surgery.

1. This patient does not require additional physical therapy. The record indicates that XXXX has poor potential for rehabilitation. The therapy since XXXX surgery has not helped XXXX significantly. Additional therapy for a prosthesis with poor function is not recommended.

2. This patient has significant limitations in XXXX ability to care for XXXX. XXXX needs assistance with all activities. The Official Disability Guidelines (ODG) supports home health services on an "intermittent" basis. A home health aide is medically necessary for this patient at the present time. If no additional surgery is proposed, an alternative plan for long-term care should be determined.

The request for PT 2x9 (18 visits), Home Health Aide for 24 hours/a day, 7 days/wk for 9 weeks (1512) hours is found to be partially medically necessary.

ODG Guidelines:
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

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)**