

# **RYCO MedReview**

**DATE OF REVIEW:** 07/13/07

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Purchase of a motorized scooter

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

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with M.D. dated xx/xx/xx, 05/22/95, 06/16/95, 06/30/95, 07/18/95, 07/28/95, 08/15/95, 09/18/95, 10/26/95, 11/22/95, 11/30/95, 12/13/95, 01/22/96, 02/15/96, 03/28/96, 04/01/96, 04/29/96, 06/10/96, 07/22/96, 09/05/96, 10/03/96, 10/31/96, 12/05/96, 02/03/97, 02/24/97, 04/07/07, 05/22/97, 06/02/97, 07/28/97, 09/15/97, 10/17/97, 10/28/97, 11/13/97, 03/30/98, 06/22/98, 07/17/98, 08/18/98, 12/02/98, 10/01/99, 10/11/99, 05/10/00, 10/17/00, 02/19/01, 04/23/01, 06/13/01, 10/05/01, 01/02/02, 02/25/02, 04/15/02, 05/10/02, 05/30/02, 06/18/02, 10/22/02, 03/31/03, 02/11/04, 03/08/04, 08/18/04, 01/04/05, 02/28/07, 06/11/07

Prescriptions from Dr. dated 03/16/07 and 07/09/07  
A letter of denial from, M.D. at Insurance dated 05/09/07  
A letter of denial from, M.D. at Insurance dated 06/04/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

On xx/xx/xx, Dr. requested tomograms of the left femur and possible surgery. On 06/30/95, Dr. applied a short leg cast and recommended non-weightbearing and crutches. On 08/15/95, Dr. recommended an air splint and surgery. On 10/26/95, Dr. noted the patient was post surgery and recommended non-weightbearing. On 11/22/95, Dr. requested an ultrasonic device for bone healing. On 01/22/96, Dr. requested removal of the brace and range of motion of the knee. On 04/29/96, Dr. recommended continuation of the bone stimulator unit and psychiatric treatment. On 10/03/96, Dr. requested a heel lift. On 05/22/97, Dr. requested buddy taping of the toes, a Reece shoe, and continued crutch use. On 07/28/97, Dr. performed a radial tunnel injection. On 09/15/97, Dr. prescribed Darvocet and Voltaren. On 03/30/98, Dr. prescribed heel lifts. On 07/17/98, Dr. requested removal of the screw from the knee. On 10/01/99, Dr. prescribed Darvocet and Arthrotec. On 10/17/00, Dr. prescribed a therapeutic hot tub and a wrist cuff. On 02/19/01, Dr. performed a left shoulder trigger point injection. On 04/23/01, Dr. requested an MRI of the cervical spine. On 10/05/01, Dr. requested continuation of a home exercise program. Dr. requested an EMG/NCV study of the right leg on 01/08/02. On 04/16/02, Dr. recommended physical therapy and Vicodin. On 05/30/02, Dr. requested continuation of a TENS unit. Dr. prescribed a new walker on 10/22/02. Dr. requested continued use of a cane, Ultram, and Prozac on 03/31/03. On 03/08/04, Dr. requested physiotherapy. On 03/16/07, Dr. prescribed a motorized scooter. On 05/09/07, Dr. wrote a letter of denial for the motorized scooter. On 06/04/07, Dr. also wrote a letter of denial for the motorized scooter. On 07/09/07, Dr. continued to request a motorized scooter.

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

This would be a luxury/convenience item. The most common criteria for purchase of a motorized scooter are those promulgated by. In this criterion, it is noted that a scooter is only authorized for individuals who are not ambulatory in their home situation. This patient is ambulatory with a cane or a crutch. Therefore, she does not meet the commonly most accepted criteria for the use of a motorized scooter. While Dr. may well be right that the patient has a better quality of life with a scooter, it is neither reasonable nor necessary due to the failure to adhere to the criteria most commonly accepted for his purchase.

**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)