

SENT VIA EMAIL OR FAX ON  
Aug/17/2009

## Applied Resolutions LLC

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/13/2009

**IRO CASE #:**

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

Purchase of Pride Victory 9 Scooter

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 6/1/09 and 6/15/09  
Dr. 6/25/09 and 8/5/09  
Dr. 5/7/09  
6/1/09 thru 7/24/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a xxyear-old woman with a traumatic brain injury, right BKA and left AKA following a xxxx injury. She has a scooter that tips on uneven surfaces. The battery is dead and the seat is too small. She has been fitted with prostheses and received inpatient rehabilitation and out patient therapy. Dr. reports she is unable to walk. The therapist, said that the reason for the

scooter is that the "Seat is too small; Scooter tips over on uneven surfaces; Scooter doesn't run." The battery load test failed. She wrote that the base of support is too small and that the manufacturer cannot provide a larger seat for her current model. Further she tested a model of the newer one in her home.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The ODG does describe the need and justification for power mobility devices. She demonstrated the need for one with the extent of her injuries. It would appear that whoever measured her for the one she currently has did not provide adequate measurements for the seat and the base of support. The tilting over of the scooter will leave her possibly injured and unable to move. The question is why the wrong model was chosen and why it is mechanically unreliable. These are issues to be considered, but are not directly the purpose of the review.

Dr. said she tested the model out at her home and it was satisfactory. A 4 wheeled chair may provide a better base of support. The Reviewer presumes that she has the cognition and vision to operate any powered mobility device.

The Reviewer finds the reasons for the new scooter to be valid to avoid injury.

#### **Power mobility devices (PMDs)**

Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. ([CMS, 2006](#)) Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. See also [Immobilization](#).

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)