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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/14/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Purchase of a Lift Chair with Pillow

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

M.D., Board Certified Orthopedic Surgeon

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

Office notes, Dr., 12/13/90, 05/15/91, 04/13/92, 0/22/92, 02/11/93, 09/02/93, 11/15/93, 02/05/96, 08/19/97, 02/05/08, 05/07/98, 09/10/09, 10/19/09

Myelogram, Dr., 04/01/92

OR note, 08/04/93, 10/31/97

X-rays, 06/12/95

Myelogram, 09/27/95

MRI, 10/01/09

Peer review, Dr., 11/05/09

Peer review, Dr., 11/13/09

Hospital Records, 1993, 1997

X-ray, 09/02/93, 12/27/93, 08/18/97, 11/24/97, 02/05/98, 05/07/98, 09/11/09

ODG Guidelines (Do not apply)

PATIENT CLINICAL HISTORY SUMMARY

This patient was seen from xxxx to 1990 for low back and right leg pain. In xxxx, the claimant had chemonucleolysis with some relief of leg pain. He had diagnostic studies that showed an L4-5 herniation on the right into the lateral recess. On 09/30/86 the claimant had a right L4-5 laminectomy, foraminotomy and discectomy for low back and right leg pain. By 12/86 the claimant was doing well and leg pain had been relieved.

The back and right leg pain returned and on 01/10/90, the claimant had right L4-5 exploration with excision of a recurrent herniation and nerve root decompression. He was treated with therapy and medications. The records from July 1990 showed the claimant was working as a and had some back pain and right leg pain. In 12/90 and 03/91, the back and leg pain persisted. He had positive seated straight leg raise. The claimant requested, and Dr. ordered a self-lift chair.

On 04/01/92 a myelogram by Dr. showed a central and right L4-5 defect. Visits in 04/92 and 06/92 indicated the claimant had ongoing pain in the back and knees. Fusion was discussed.

On 08/04/93 the claimant had decompression and interbody fusion at L4-5. He did well for a time. On 11/15/93, Dr. reported the claimant had back pain and x-rays showed anterior displacement L4-5 with loss of disc space at L4-5. The claimant was reported to have good lower extremity strength. 1994 records showed he had ongoing low back pain but no radiation of pain. Strength in the lower extremities was documented as "good" but flexibility was mildly decreased.

The 06/12/95 x-rays with flexion/extension showed marked loss of the L4-5 joint space, sclerosis of endplates and mild subluxation of L4 on 5. There was no movement with flexion/extension. A 09/27/95 myelogram documented decreased disc height with grade I spondylolisthesis and mild indentation of the thecal sac at L4-5. There was decreased filling of both L5 nerve roots. In 1996, the claimant's pain was worse.

On 08/19/97, Dr. noted the claimant had not been seen for 1 year and had returned with back and bilateral leg pain. Motion was limited in all directions and there was loss of lordosis. On 10/31/97 the claimant underwent L3-4 and 4-5 bilateral decompression and transverse process fusion, graft, pedicle screws and plates.

By 02/05/98, Dr. noted the claimant had no back or hip pain and that he was no longer taking pain medications. On examination, he was walking well and x-rays showed progressive fusion with good position of instrumentation. In 05/98, the fusion was documented a solid.

Records lapsed until 09/10/09. Dr. saw the claimant for increasing lumbar pain for 1 year and bilateral hip and leg pain with numbness. On examination he had decreased mobility, a flexed posture and straight leg raise caused low back and posterior thigh pain bilaterally at 45-60 degrees. He had absent reflexes in the lower extremities and difficulty toe and heel standing.

A 10/01/09 MRI of the lumbar spine showed L1-2 and 2-3 disc bulging with encroachment on the thecal sac; degenerative changes of the facets and thickening of the ligamentum flavum; mild to moderate canal stenosis at L1-2 and prominent stenosis with bilateral foraminal narrowing at L2-3

On 10/19/09, Dr. noted the claimant had severe radicular pain with numbness, dysesthesias and weakness as well as back pain. There was quadriceps, dorsiflexion and plantar flexion weakness and positive straight leg raise. A CT and a lift chair were recommended.

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

The reviewer is unable to recommend as medically necessary the lift chair in this case. The medical records included do not indicate that this claimant is not able to stand without the use of such a device. The device cannot be considered a necessary medical treatment. The reviewer finds that medical necessity does not exist at this time for 1 Purchase of a Lift Chair with Pillow.

Official Disability Guidelines 2010 does not apply

Medicare National Coverage Determinations Manual Chapter 1, Part 4, Sections 200-300.1.
Coverage Determination 280.4-Seat Lift

Reimbursement may be made for rental or purchase of a medically necessary seat when prescribed by a physician for a patient with severe arthritis of the hip or knee and patients with muscular dystrophy or other neuromuscular disease when it has been determined that patient can benefit therapeutically from use of the device....”

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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

Medicare National Coverage Determinations Manual Chapter 1, Part 4, Sections 200-300.1.
Coverage Determination 280.4-Seat Lift