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Amended Notice of Independent Review Decision

**DATE OF REVIEW:** May 11, 2010 – Original IRO  
May 13, 2010 – Amended IRO

**IRO CASE #:**

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

DME purchase of a heavy duty power wheelchair, one purchase of flip up height adjustable armrest, high back captain's seat, one purchase of heavy duty gel battery, articulating leg rest with aluminum footplates, S.

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

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY  
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

**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**

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- xxxxx, 01/08/10
- Home Evaluation, 02/02/10
- M.D., 01/25/10, 02/09/10, 02/19/10, 02/23/10
- xxxxx, 02/23/10, 03/09/10
- 05/15/10, 05/30/10
- 04/27/10

Medical records from the Provider include:

- 01/26/10, 02/09/10, 02/19/10, 03/01/10, 03/17/10, 03/26/10

**PATIENT CLINICAL HISTORY:**

To Whom It May Concern:

I have had the opportunity to review medical records on this patient. The purpose of the IRO is to determine the medical necessity of a heavy duty power wheelchair with adjustable armrests, high back captain seat, gel battery, and articulating leg rests.

The initial medical records is an operative report dated xxxxxx, in which the patient underwent removal of a total knee arthroplasty with placement of antibiotic cement spacer. There was a wound VAC applied at that time.

A letter was written on February 23, 2010, and it recounts an on-the-job injury having occurred in July of 2005. The letter indicates that the patient had undergone a knee fusion. He also had sleep apnea, hypertension, and asthma, as well as morbid obesity. The note indicates that the patient weighed 420 pounds. The power mobility device was declined by the carrier. A peer review had been performed by, M.D.

A second review was performed by D.O, orthopedic surgeon, who also declined the request for a power wheelchair, citing ODG Guidelines. The request was denied because the patient could propel a standard wheelchair with his upper extremities.

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

It is my opinion that the non-certification of the power wheelchair was appropriate according to the ODG Guidelines. The patient has no medical condition that would result in his inability to self-propel a wheelchair. Therefore, it is my opinion that the power wheelchair is not medically necessary and that the non-certification by the carrier was appropriate.

I trust that this will be sufficient for your needs.

**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)