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Notice of Independent Review Decision

DATE OF REVIEW: 10/15/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH

Repair of wheelchair Purchase of: #E2607 Slimline 18 who X 20 #E2363 group of 24 batteries #E2394 wheel eight spoke three X eight knob pneumatic caster #K0019 arm rest pad left #K0019 arm rest pad right #E2615 solid backrest assembly #K0077 micro caster lighted #E2219 casters with the pneumatic inserts #K0108 remote box without jack #E2370 motor mount assembly #E2370 motor mount assembly.

DATES OF SERVICE FROM 09/02/2010 TO 09/02/2010

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 08/07/01 - Electrodiagnostic Studies
2. 12/18/01 - Letter - M.D.
3. 02/06/02 - History and Physical
4. 01/02/02 - Clinical Note - M.D.
5. 01/30/02 - Clinical Note - M.D.
6. 02/12/02 - Operative Report

7. 02/20/02 - Clinical Note - M.D.
8. 03/27/02 - Clinical Note - M.D.
9. 04/24/02 - Clinical Note - M.D.
10. 05/22/02 - Clinical Note - M.D.
11. 06/20/02 - Operative Report
12. 07/01/02 - Clinical Note - M.D.
13. 07/08/02 - Clinical Note - M.D.
14. 08/07/02 - Clinical Note - M.D.
15. 09/18/02 - Clinical Note - M.D.
16. 10/09/02 - Clinical Note - M.D.
17. 11/07/02 - Electrodiagnostic Studies
18. 11/25/02 - Upper Arterial Venous Study
19. 11/27/02 - Clinical Note - M.D.
20. 01/13/03 - Clinical Note - M.D.
21. 04/14/03 - Clinical Note - M.D.
22. 05/23/03 - Operative Report
23. 06/04/03 - Clinical Note - M.D.
24. 06/23/03 - MRI Cervical Spine
25. 09/15/03 - Clinical Note - M.D.
26. 10/07/03 - Operative Report
27. 12/18/03 - MRI Left Thoracic Outlet
28. 01/14/04 - Clinical Note - M.D.
29. 02/09/04 - Clinical Note - M.D.
30. 03/10/04 - Clinical Note - M.D.
31. 03/24/04 - Angiography Cervicocerebral Arch
32. 04/21/04 - Clinical Note - M.D.
33. 07/14/04 - Clinical Note - M.D.
34. 08/04/04 - MRI Lumbar Spine
35. 09/02/04 - Electrodiagnostic Studies
36. 10/27/04 - Clinical Note - M.D.
37. 12/06/04 - Clinical Note - M.D.
38. 01/03/05 - Clinical Note - M.D.
39. 02/14/05 - Clinical Note - M.D.
40. 03/28/05 - Clinical Note - M.D.
41. 09/28/05 - Clinical Note - M.D.
42. 03/27/06 - Clinical Note - LSA, OPA-C
43. 05/11/06 - Required Medical Examination
44. 09/25/06 - Clinical Note - M.D.
45. 03/30/07 - Clinical Note - M.D.
46. 05/03/07 - Radiographs Thoracic Spine
47. 09/24/07 - Clinical Note - M.D.
48. 03/17/08 - Clinical Note - M.D.

49. 09/22/08 - Clinical Note - M.D.
50. 11/24/08 - MRI Lumbar Spine
51. 12/10/08 - Clinical Note - M.D.
52. 12/22/08 - Clinical Note - M.D.
53. 12/22/08 - Procedure Notes
54. 02/09/09 - Clinical Note - M.D.
55. 08/12/09 - Clinical Note - M.D.
56. 08/19/09 - Clinical Note - M.D.
57. 09/16/09 - MRI Cervical Spine
58. 09/23/09 - Clinical Note - M.D.
59. 11/04/09 - Clinical Note - M.D.
60. 11/06/09 - Operative Report
61. 11/23/09 - Clinical Note - M.D.
62. 04/21/10 - Clinical Note - M.D.
63. 09/01/10 - Wheelchair Repair Quote
64. 09/07/10 - Utilization Review
65. 09/24/10 - Utilization Review
66. 09/29/10 - Letter - M.D.
67. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a male who sustained an injury on xx/xx/xx when he fell down a flight of stairs while.

The clinical notes begin with electrodiagnostic studies performed 08/07/01 that revealed significant median nerve entrapment at both wrists and bilateral ulnar nerve entrapment at both elbows. Electromyography was normal of both upper extremities.

The claimant underwent left ulnar nerve transposition at the elbow and re-exploration of the left carpal tunnel with external neurolysis at the left median nerve on 02/12/02.

The claimant underwent re-exploration of the right carpal tunnel, decompression of the ulnar nerve and cubital tunnel of the right elbow, and neurolysis on 06/20/02.

Electrodiagnostic studies performed 11/07/02 reveal electrodiagnostic evidence of bilateral carpal tunnel syndrome and left C8 radiculopathy with ongoing denervation.

An Upper Arterial Venous Study performed 11/25/02 demonstrated reduced arterial flow with all thoracic outlet maneuvers on the left.

The claimant underwent cervical epidural steroid injection at C5-6 on 05/23/03.

An MRI of the cervical spine performed 06/23/03 demonstrated a 2 mm posterior protrusion at C4-C5 and C6-C7 that mildly indented the thecal sac. There was no central canal stenosis or remarkable foraminal narrowing.

The claimant underwent lumbar epidural steroid injection at L3-L4 on 10/07/03.

An MRI of the left thoracic outlet performed 12/18/03 demonstrated no evidence of nerve root edema within the brachial plexus.

An angiography of the cervicocerebral arch performed 03/24/04 revealed widely patent inflow with normal thoracic arch and normal supra-aortic branches without evidence of thoracic outlet syndrome. There was abnormal blow to the digital arteries with morphological changes consistent with bilateral Raynaud's Syndrome.

An MRI of the lumbar spine performed 08/04/04 demonstrated epithelial fibrosis at the surgical site at L5-S1 with no evidence of recurrent disc herniation. No arachnoiditis was noted. No meningocele was noted.

Electrodiagnostic studies performed 09/02/04 revealed an abnormal study with electrodiagnostic evidence of a bilateral S1 radiculopathy.

The claimant saw Dr. on 01/03/05, requesting a letter stating that he has lost use of the lower extremities due to paralysis. Dr. refused, stating the claimant lacked strength and function but he was not paralyzed.

The claimant received steroid injections to both wrists on 03/28/05 A Required Medical Examination (RME) was performed on 05/11/06. The claimant complained of pain in the neck, low back, and both legs, as well as both hands and wrists. The claimant also reported numbness in both hands and both legs from thigh to toes. The claimant stated his activities were limited due to

weakness in the hands and legs. The claimant reported bladder dysfunction and sexual dysfunction. The note stated the claimant had lumbar surgery in March 1995 and lumbar laminectomy in March 1996. The claimant arrived to the office in an electric-powered wheelchair, which he stated he used in public. The claimant stated he used a manual wheelchair at home. He was able to transfer out of the chair independently and stand independently. Physical examination revealed the claimant was able to stand on his toes and heels while holding on to the examination table, but he was unable to walk. There was minimal active lumbar flexion, extension, and bending due to pain. There was no lumbar paraspinal muscle spasm or tenderness. Seated straight leg raise was to 60 degrees with complaints of mild to moderate low back pain. The hip flexors were weak secondary to back pain aggravation. Hip abduction was strong bilaterally with no aggravation of back pain. Knee extension was weak bilaterally with complaints of low back pain. Ankle extension and flexion were strong bilaterally. The claimant was unable to flex or extend the great toe due to complaints of ingrown toenails. There was marked decrease in active range of motion of shoulder adduction bilaterally secondary to increase in low back pain. There was marked decrease in effort in the left triceps. No muscle atrophy was noted in the upper or lower extremities. There was decreased sensation to light touch over the hands and both legs. The claimant was assessed with chronic pain disorder associated with psychological factors and medical condition and failed lumbar spine surgery.

Radiographs of the thoracic spine performed 05/03/07 demonstrated mild degenerative changes with mild rotoscoliosis.

An MRI of the lumbar spine performed 11/24/08 was noted to be incomplete as the claimant terminated the examination early. There was evidence of a prior surgery at L4-L5 and L5-S1. The spinal canal was well-decompressed at both levels. The neural foramina appeared mildly encroached to normal in caliber at both segments. There was loss of disc signal, mild ligamentous thickening, and bony hypertrophic changes at the upper three lumbar levels. The neural foramina appeared only mildly encroached at these levels. There appeared to be some mild rotoscoliosis.

The claimant underwent refill of intrathecal narcotics pump and pump analysis with reprogramming on 12/22/08.

The claimant saw Dr. on 08/12/09 with complaints of low back and neck pain. Current medications included morphine, Clonidine, and Fentanyl. The

claimant ambulated in a wheelchair. Physical examination revealed the intrathecal narcotic pump tip located at the 4 o'clock position in the right lower abdominal quadrant. Neurological examination was unremarkable. The claimant was assessed with status post lumbar fusion, chronic intractable low back pain, and status-post intrathecal catheter replacement. The claimant was prescribed Maxalt, Zanaflex, Elavil, and Mobic. The claimant's pain pump was reprogrammed and refilled.

The claimant saw Dr. on 08/19/09 with complaints of neck pain that radiated to both shoulders. Physical examination revealed limited range of motion of the head and neck. The claimant was assessed with degenerative disc disease of the cervical spine. The claimant was recommended for an MRI of the cervical spine.

An MRI of the cervical spine performed 09/16/09 demonstrated loss of disc signal with 1 mm disc bulges, ligamentous thickening, and mild bony hypertrophic changes at C3-C4 and C4-C5. The anterior CSF space was partially effaced. The spinal canal does remain well in excess of a centimeter at both levels. The neural foramina appear minimally encroached. There was straightening of the cervical spine with mild reversal of its normal curvature.

The claimant saw Dr. on 11/04/09 with complaints of lumbar pain. Physical examination was deferred. The claimant was recommended for facet blocks at L4-L5 and L5-S1.

The claimant underwent bilateral L4-L5 and L5-S1 facet blocks on 11/06/09.

The claimant saw Dr. on 11/23/09. The claimant reported some relief from the injections. There was no change in physical examination per the clinical note. The claimant was assessed with bilateral L4-L5 and L5-S1 facet arthropathy. The claimant was recommended for fusion from L4 to sacrum. Otherwise, the claimant was advised to follow up in six months.

The claimant saw Dr. on 04/21/10 with complaints of pain in the back and both legs, as well as swelling in both feet. The note stated there was no change in physical examination. The claimant was assessed with chronic low back pain secondary to degenerative disc and facet arthropathy and dependent edema of both lower extremities. The claimant was given a prescription for eight pair of Jobst stockings. He was advised to follow-up in six months.

A prescription was provided to the claimant on 07/07/10 for electric wheelchair repair.

The request for skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth is denied by utilization review on 09/07/10 due to lack of documentation to objectively support the request for repair of the wheelchair. According to the records, the claimant was capable of using a manual wheelchair. It is unclear whether he recently received a new wheelchair, and the medical necessity of this repair has not been clearly demonstrated.

The request for skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth was denied by utilization review on 09/24/10 due to minimal clinical documentation demonstrating the claimant's current functional status or rationale as to why the claimant cannot appropriately self-power a manual wheelchair.

A letter by Dr. dated 09/29/10 stated the claimant had been in a wheelchair for years, and it was unlikely that exercise or mobilization would help. The claimant was unable to use a manual wheelchair due to bilateral carpal tunnel syndrome and cubital tunnel syndrome of both elbows. The letter stated the claimant had continued swelling in both radio-carpal joints, which have been injection numerous times. Dr. also opined that the claimant's lumbar and cervical complaints would be aggravated by continually pushing himself in a manual wheelchair.

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

The clinical documentation provided for review does not support the request for a wheelchair seat cushion Repair of wheelchair Purchase of: #E2607 Slimline 18 who X 20 #E2363 group of 24 batteries #E2394 wheel eight spoke three X eight knob pneumatic caster #K0019 arm rest pad left #K0019 arm rest pad right #E2615 solid backrest assembly #K0077 micro caster lighted #E2219 casters with the pneumatic inserts #K0108 remote box without jack #E2370 motor mount assembly #E2370 motor mount assembly.

While the claimant has been using a powered wheelchair for several years, there is no evidence provided that the claimant would have any improvement in function with the requested seat cushion and supplies. The clinical notes indicate that the claimant does not physically require a power wheelchair, and the claimant is choosing to use a wheelchair to function.

Without evidence that the claimant would have improved functional capabilities with a new wheelchair cushion and supplies or that the current wheelchair cushion significantly limits the claimant's functional abilities, medical necessity is not supported.

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

Official Disability Guidelines, Online Version, Knee and Leg Chapter