



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 04/01/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute:	Request Received Date
appeal Teh Lin 4 wheel scooter	03/08/2011
appeal Bruno outsider meridian lift to accommodate travel	03/08/2011
appeal Swing away	03/08/2011
appeal Labor 10 hrs @ 75 to install	03/08/2011

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

Texas Board Certified Family Practice

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. Xx/xx/xx- Employers First Report of Injury or Illness
2. Xx/xx/xx- Initial Medial Report
3. 10/13/92 - Specific and Subsequent Medical Report
4. 10/21/92 - Specific and Subsequent Medical Report
5. 11/10/92 - Specific and Subsequent Medical Report
6. 11/25/92 - Specific and Subsequent Medical Report
7. 12/15/92 - Specific and Subsequent Medical Report
8. 01/12/93 - Specific and Subsequent Medical Report
9. 02/12/93 - Specific and Subsequent Medical Report
10. 03/19/93 - Specific and Subsequent Medical Report
11. 03/26/93 - Functional Capacity Comprehensive Report

12. 06/09/93 - Clinical Note - MD
13. 07/28/93 - Operative Report
14. 08/30/93 - Specific and Subsequent Medical Report
15. 09/07/93 - Physical Therapy Note
16. 09/08/93 - Physical Therapy Note
17. 09/09/93 - Physical Therapy Note
18. 09/14/93 - Physical Therapy Note
19. 09/27/93 - Ankle and Foot Evaluation
20. 09/27/93 - Physical Therapy Note
21. 09/27/93 - Physician's Status Report
22. 09/29/93 - Physical Therapy Note
23. 11/01/93 - Specific and Subsequent Medical Report
24. 12/14/93 - Physical Therapy Note
25. 12/15/93 - Physical Therapy Note
26. 01/04/94 - Physical Therapy Note
27. 01/05/94 - Physical Therapy Note
28. 01/06/94 - Physical Therapy Note
29. 01/10/94 - Physical Therapy Note
30. 01/11/94 - Physical Therapy Note
31. 01/14/94 - Physical Therapy Note
32. 01/17/94 - Physical Therapy Note
33. 01/19/94 - Physical Therapy Note
34. 01/21/94 - Physical Therapy Note
35. 01/24/94 - Physical Therapy Note
36. 01/25/94 - Physical Therapy Note
37. 01/26/94 - Physical Therapy Note
38. 01/31/94 - Physical Therapy Note
39. 02/07/94 - Request for Preauthorization of Medical Treatment/Service
40. 07/28/94 - Clinical Note - MD
41. 08/01/94 - Letter - MD
42. 08/17/94 - Clinical Note - MD
43. 08/24/94 - CT Right Lower Extremity
44. 08/31/94 - History and Physical
45. 08/31/94 - Radiographs Chest
46. 09/19/94 - Impairment Evaluation
47. 09/28/94 - Clinical Note - MD
48. 10/07/94 - MRI Right Ankle
49. 10/10/94 - Letter - MD
50. 10/11/94 - Clinical Note - MD
51. 12/08/94 - Clinical Note - MD
52. 12/22/94 - Letter - MD
53. 12/22/94 - Report of Medical Evaluation
54. 01/04/95 - Clinical Note - MD
55. 01/17/95 - Request for Preauthorization of Medical Treatment/Service
56. 01/18/95 - Clinical Note - MD
57. 02/22/95 - Clinical Note - MD
58. 03/13/95 - Letter - MD
59. 04/05/95 - Clinical Note - MD
60. 04/05/95 - Initial Rehabilitation Nurse Consultant Report

04/20/95 - Psychological Evaluation

61. 05/09/95 - Individual Psychotherapy Note
62. 05/15/95 - Rehabilitation Progress Report
63. 05/23/95 - Individual Psychotherapy Note
64. 06/06/95 - Individual Psychotherapy Note
65. 06/14/95 - Clinical Note - MD
66. 06/20/95 - Individual Psychotherapy Note
67. 06/26/95 - Clinical Note - MD, PhD
68. 06/28/95 - Clinical Note - MD
69. 06/29/95 - Individual Psychotherapy Note
70. 07/17/95 - Clinical Note - MD, PhD
71. 07/27/95 - Clinical Note - MD
72. 08/23/95 - Clinical Note - MD
73. 10/04/95 - Clinical Note - MD
74. 11/15/95 - Clinical Note - MD
75. 11/29/95 - Clinical Note - MD
76. 12/26/95 - Clinical Note - MD
77. 01/31/96 - Clinical Note - MD
78. 04/17/96 - Operative Report
79. 05/01/96 - Clinical Note - MD
80. 05/06/96 - Letter - MD
81. 06/12/96 - Clinical Note - MD
82. 08/21/96 - Clinical Note - MD
83. 10/23/96 - Clinical Note - MD
84. 12/13/96 - Clinical Note - MD
85. 01/29/97 - Letter - MD, PhD
86. 02/19/97 - Clinical Note - MD
87. 10/29/97 - Clinical Note - MD
88. 12/10/97 - Clinical Note - MD
89. 01/14/98 - Letter - MD
90. 01/28/98 - History and Physical
91. 02/25/98 - Clinical Note - MD, PhD
92. 04/10/98 - Biofeedback Session Report
93. 04/16/98 - Biofeedback Session Report
94. 07/29/98 - Clinical Note - MD, PhD
95. 01/19/99 - Clinical Note - MD
96. 02/10/99 - Appeal Letter - MD, PhD
97. 02/17/99 - Clinical Note - MD, PhD
98. 09/01/99 - Clinical Note - MD, PhD
99. 11/17/99 - Psychological Assessment Report
100. 03/29/00 - Letter - MD, PhD
101. 04/18/00 - Biofeedback Session Report
102. 04/19/00 - Biofeedback Session Report

04/24/00 - Individual Psychotherapy Note
103. 05/02/00 - Letter - PhD
104. 05/02/00 - Clinical Note - MD
105. 05/03/00 - Biofeedback Session Report
106. 08/02/00 - Individual Psychotherapy Note
107. 08/09/00 - Individual Psychotherapy Note
108. 08/23/00 - Individual Psychotherapy Note
109. 09/06/00 - Individual Psychotherapy Note
110. 10/04/00 - Clinical Note - MD, PhD
111. 10/11/00 - Individual Psychotherapy Note
112. 10/18/00 - Individual Psychotherapy Note
113. 10/25/00 - Clinical Note - MD, PhD
114. 11/08/00 - Clinical Note - MD, PhD
115. 11/08/00 - Letter - MD, PhD
116. 12/06/00 - Clinical Note - MD, PhD
117. 01/04/01 - Clinical Note - MD, PhD
118. 01/23/01 - Clinical Note - MD
119. 01/31/01 - Clinical Note - MD, PhD
120. 02/21/01 - Clinical Note - MD, PhD
121. 04/18/01 - Clinical Note - MD, PhD
122. 05/23/01 - Clinical Note - MD, PhD
123. 06/12/01 - Clinical Note - MD
124. 06/20/01 - Clinical Note - MD, PhD
125. 07/13/01 - Arthrogram Right Shoulder
126. 10/16/01 - Clinical Note - MD
127. 02/04/02 - Clinical Note - MD
128. 03/13/02 - Letter - MD, PhD
129. 04/01/02 - MD, PhD
130. 04/10/02 - Operative Report
131. 05/22/02 - Clinical Note - MD
132. 07/08/02 - Peer Review
133. 07/15/02 - Clinical Note - MD, PhD
134. 07/24/02 - Abdominal Ultrasound
135. 09/08/03 - Clinical Note - MD
136. 10/20/03 - Letter - CO
137. 10/23/03 - Clinical Note - MD
138. 01/05/04 - Clinical Note - MD
139. 10/25/04 - Clinical Note - MD
140. 01/10/05 - Clinical Note - MD
141. 01/11/05 - Clinical Note - MD
142. 02/22/05 - Clinical Note - MD
143. 05/24/05 - Clinical Note - MD
144. 07/05/05 - Clinical Note - MD

- 08/02/05 - Clinical Note - MD
- 145. 09/19/05 - Clinical Note - MD
- 146. 04/10/06 - Clinical Note - MD, PhD
- 147. 08/04/06 - Laboratory Report
- 148. 10/10/07 - Radiographs Left Hand
- 149. 10/10/07 - Radiographs Right Foot
- 150. 10/01/08 - Clinical Note - MD
- 151. 10/01/08 - Laboratory Report
- 152. 10/02/08 - Radiographs Thoracic Spine
- 153. 10/23/08 - Clinical Note - MD
- 154. 10/23/08 - Texas Work Status Report
- 155. 11/24/08 - Clinical Note - MD
- 156. 09/21/09 - Clinical Note - DPM
- 157. 08/19/10 - Radiographs Lumbar Spine
- 158. 12/07/10 - Clinical Note - Unspecified Provider
- 159. 12/07/10 - Letter - MD
- 160. 01/26/11 - Clinical Note - DPM
- 164. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he slipped and fell in the parking lot.

A Functional Capacity Evaluation (FCE) was performed on 03/26/93. The employee's occupation as a requires a very heavy physical demand level. The employee was currently functioning at a heavy physical demand level.

The employee underwent arthroscopic debridement of osteochondral fragments, posterior medial arthrotomy, and debridement of osteochondritis dissecans on 07/28/93.

The employee attended twenty-one physical therapy sessions from 09/07/93 through 01/31/94.

CT of the right lower extremity performed 08/24/94 demonstrated a small deficit measuring 3.5 mm in the posterior medial dome of the talus compatible with an area of osteochondritis dissecans. There was a small fragment of bony material in this defect. There was no evidence of loose bony fragment within the ankle. There was no way to determine if the bony fragment identified in the osteochondral defect was mobile.

The employee was seen for impairment evaluation on 09/19/94. The employee complained of constant burning pain in the right ankle, as well as occasional low back pain and left wrist pain. Current medications included Vicodin. Physical examination

revealed full strength of the left lower extremity. There was decreased strength of the right lower extremity secondary to pain. There was decreased sensation to light touch and pinprick just proximal to the right ankle and distally to the toes. The employee was assessed with right ankle fracture with subsequent reflex sympathetic dystrophy. The employee was assigned a 24% whole person impairment.

MRI of the right ankle dictated on 10/07/94 demonstrated small osteocondylar defect with cortical irregularity noted on the medial aspect of the talar dome. There were no significant changes when compared to the previous study.

The employee was seen for psychological evaluation on 04/20/95. The note stated the employee functions in the average range of intelligence. The employee demonstrated good judgment, good social reasoning, and good problem-solving ability. The note stated the employee was a good candidate for a dorsal column stimulator.

The employee attended five psychotherapy sessions from 05/09/95 through 06/29/95.

The employee was seen for psychological assessment on 11/17/99. The employee's problem list included an inability to pace activities, possible escalating usage of pain medications, weight gain, maladaptive coping, hyperarousal and perceptual hypervigilance, and lack of pain coping strategies. Psychological testing was not performed. The employee was assessed with pain disorder with psychological and medical factors and anxiety due to a general medical condition. The employee was recommended for twelve individual psychotherapy sessions and twelve biofeedback treatment sessions.

The employee attended six psychotherapy sessions from 08/02/00 through 10/18/00.

An arthrogram of the right shoulder performed 07/13/01 demonstrated no evidence of full thickness rotator cuff tear. There was a degenerative appearing subchondral cyst associated with the greater tuberosity.

The employee underwent incision and revision of subcutaneous pocket for pulse generator and removal of old Itrel III system with replacement of new Itrel III pulse generator on 04/10/02.

An abdominal ultrasound performed 07/24/02 demonstrated fatty metamorphosis of the liver. The employee was status post cholecystectomy and right nephrectomy. The pancreas was largely obscured by overlying bowel gas.

Radiographs of the left hand performed 10/10/07 were unremarkable. Radiographs of the right foot performed 10/10/07 revealed generalized osteopenia of the bony framework and diffuse soft tissue swelling of the right foot, consistent with the diagnosis

of reflex sympathetic dystrophy. There are moderate subluxations of the right second through fifth PIP joints.

Radiographs of the thoracic spine performed 10/02/08 were unremarkable. There was a spinal cord stimulator in place with the lead entering the T12-L1 level and extending superiorly to the level of the T9-T10 disc space.

The employee saw Dr. on 09/21/09. Physical examination revealed rigid calcaneovarus deformity noted in the right lower extremity, as well as a rigid contracture at the ankle with a flexed supination position. There was no range of motion noted at the subtalar joint nor the ankle joint. There was hypersensitivity noted in the right lower extremities. There was a thick dystrophic nail noted. The employee was assessed with status post crush injury in xxxx with rigid contracture of foot and ankle with calcaneovarus deformity with painful supination. The employee was fitted with new custom-molded boots and shoes with patellar weight bearing brace connected to boot with T-strap.

Radiographs of the lumbar spine performed 08/19/10 demonstrated lumbar spondylosis without acute abnormality.

The employee was seen for evaluation on 12/07/10. The note stated the employee had a spinal cord stimulator implanted in 1994 and 2001. Physical examination revealed tenderness in the right knee with moderate pain with motion. Lumbar and thoracic mobility are decreased. The right foot/ankle has contracted. The note stated there was toenail dystrophy. The employee was assessed with lumbago, pain in hip joint, and pain in ankle/foot.

A letter by Dr. dated 12/07/10 stated the employee sustained an injury to the right lower extremity in xxxx, and subsequently developed complex regional pain syndrome. Management had included prescription medications, physical therapy, and spinal cord stimulation. The employee was noted to be functional with the aid of a boot with brace, but he continued to have pain that was managed with prescription medications. The employee had requested a scooter so that he was able to ambulate without the boot and brace, as the boot and brace was a complicated device and can take up to twenty minutes to put on.

The employee saw Dr. on 01/26/11. Physical examination revealed a supinated gait. The employee was assessed with status post crush injury in xxxx with rigid contracture of foot and ankle with calcaneal varus deformity and painful supinated gait. The employee was sent to orthotist for new custom molded boots and shoes with patellar weight bearing brace connected to boot with T-strap. The employee was advised to follow up as needed.

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

The request for a Teh Lin 4 wheel scooter, Bruno outsider meridian lift to accommodate travel, Swing away, Labor 10 hrs to install would not be considered medically necessary. The clinical notes indicate the employee is functional with the aid of a boot and brace, but requests the use of a scooter as the boot and brace are difficult to put on. Current evidence based guidelines do not recommend the use for a motorized scooter if there is any mobility with canes or assistive devices. As the employee is currently functional with the use of the boot and brace, medical necessity for the scooter is not established at this time. As the requested scooter is not medically necessary, the request for labor, Swing Away, and Bruno Outside Meridian Lift is not needed or warranted at this time.

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

Official Disability Guidelines, Online Version, Ankle Chapter

Indications for power mobility devices:

Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the employee 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. 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.