

SENT VIA EMAIL OR FAX ON  
Jul/25/2011

## True Decisions Inc.

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/25/2011

**IRO CASE #:**

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

Power chair, power scooter, power mobility device purchase

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

Board Certified Orthopedic 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**

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female patient who was getting out of her truck and slipped. She caught the heater hose to prevent herself from falling and injured her right shoulder. The patient was determined to have reached MMI as of 07/02/2002 with 30% whole person impairment. Treatment to date is noted to include dorsal column stimulator, diagnostic testing, right shoulder arthroscopy with debridement of labrum and rotator cuff followed by open rotator cuff repair with acromioplasty open distal clavicle resection on 03/22/06. Impairment rating dated 08/17/06 indicates that the patient underwent previous left knee total replacement in January 2002. The patient was provided 14% whole person impairment. The patient underwent left knee arthroscopy on 11/07/06, revision of poly component left total knee replacement on 12/19/06, revision of generator on 09/15/09, hardware removal on 04/15/10, revision TKR on 06/10/10 which was complicated by staph infection followed by postoperative physical therapy. Note dated 04/20/11 indicates that the patient presents with continued swelling in the bilateral lower extremities distal to the knees and presents for lymphedema services. Lower extremity functional score is 12/80. Progress note dated 05/06/11 indicates that the patient has initiated manual therapy to try to reduce the edema which has provided some benefit.

Initial request was non-certified on 06/07/11 noting that there is no documentation to indicate the need for a power chair for mobility versus a manual chair. There appear to be no functional deficits to the upper extremities. Appeal letter dated 06/21/11 indicates that the patient sustained an injury to the right upper extremity on xx/xx/xx and considering the patient's weight, knee problems, RSD and impairments involving the right upper extremity, it would be difficult for the patient to utilize a manual wheelchair. The denial was upheld on appeal dated 06/27/11 noting that the patient's ability to operate a manual wheelchair is not validated or adequately refuted in the medical records. The need for any power chair needs further validation as the patient should be able to use the regular wheelchair. A RME was recommended with an independent physiatrist or orthopedic surgeon to assess this DME use as specifically related to the work incident.

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

Based on the clinical information provided, the request for power chair, power scooter, power mobility device purchase is not recommended as medically necessary, and the two previous denials are upheld. There is no current, detailed physical examination submitted for review documenting the patient's functional status. As stated by the previous reviewers, there is a lack of documentation regarding the patient's functional ability to operate a manual wheelchair. Also, it does appear appropriate to perform an RME with an independent physiatrist or orthopedic surgeon to assess the DME use as specifically related to the work incident as recommended by the appeal level reviewer noting that the patient has a history of left total knee replacement in 2002 with subsequent complications and revision surgery; however, the patient's work related injury was to the right upper extremity. Given the current clinical data, the request is not indicated as medically necessary.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**