

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JULY 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Rear Aluminum anti-tips, black (E0971); Seat Pan Dibond (K0108)

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

DECISION This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

XX Upheld

(Agree) Overturned

(Disagr

ee)

Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
997.6, 729.5, 781.2	E0971		Prosp	2					Upheld
997.6, 729.5, 781.2	K0108		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a progress note from the amputee clinic. The injured worker is noted to be a male who had a right knee disarticulation. The claimant was wearing a below knee prosthetic device. This was augmented with the use of forearm crutches.

It was noted there was a phantom pain syndrome also being addressed. The claimant is independent to bathing, grooming, dressing, toileting, and transfers. Overall, he was noted to be independent. The gait pattern was noted to be unassisted, steady and symmetric. There were no contractors identified. There was normal strength and muscle tone and a decreased sensation noted over the incision. It was reported that the injured employee had abilities above normal relative to emulation and recreational activities and sports. The assessment was an issue with the prosthetic components.

Two separate requests for this equipment were not certified. There is no documentation of the need for these additional devices to be attached to the wheelchair.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, the use of mobility devices is recommended. However, this request is for additional parts that have no clear clinical indication. Further, the requesting provider adds no discussion as to the reason for the need of these modifications to the wheelchair. Therefore, in that the wheelchair has been recommended and employed, given that there is no objective discussion as to the need for the requested items, this request cannot be endorsed.

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

- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES