

US Decisions Inc.

An Independent Review Organization
9600 Great Hills Trail Ste 150 W
Austin, TX 78759
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/13/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

DME Power Wheel Chair Repairs

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

M.D., Board Certified Family Practice

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

Official Disability Guidelines

Adverse determination notice 11/11/11

Adverse determination after reconsideration notice 12/06/11

Quote and Mobility, not dated

Letter of medical necessity acquired new equipment 11/29/11

Outpatient therapy request form 10/31/11

Carrier response 01/02/12

Physician's order 11/30/11

Progress note Dr. 11/01/11

USM Service work order, not dated

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. He is noted to have medical history of C7 ASIA-B spinal cord. The patient was seen on 10/31/11 and reported since last visit to clinic he has been hospitalized at least 3 times due to chest pain and HTN. No records were available for review, but per patient he was hospitalized and had cardiac cath, which showed no arterial clot and discharged after that. He was also recently diagnosed with UTI, which he is in treatment with. He also presents with non-production cough for which PCP is following him. He had chest x-ray a couple of days ago but no results are available. The claimant was put on Foley for neurogenic bladder after last hospital admission and stated he is more comfortable this way. Regarding bowel movement he is doing SUPP every three days without Digital stimulation having fair results. On examination the claimant was noted with sacral wound unstagable due to Escher left ischium wound stage 3 and posterior scrotum wound stage II. An air mattress was ordered and wheelchair clinic was ordered to assess wheelchair and cushion. The claimant was to keep all pressure off area, no sitting in bed or wheelchair. The claimant was seen in outpatient wheelchair clinic for seating assessment on

11/29/11. Case manager reports denial of repairs on Permobil wheelchair, which is the claimant's primary wheelchair. The claimant arrives in his Invacare backup wheelchair today. The claimant's son states he has had sacrum and left ischial wounds for approximately 1 month due to weight loss from hospital stay. The claimant currently is using J tube deep contour cushion, which he has used over past years with good success. He is compliant with pressure reliefs using tilt mechanism. He discussed changing to Roho Quadtro cushion to use while healing wounds and after wounds are healing. The claimant notes that battery and backup chair are not holding charge. The claimant requires alternative sitting surface to accommodate weight loss and provide optimal pressure relief when sitting resumes.

A utilization review determination dated 11/11/11 determined that request for DME powered wheelchair repairs is not indicated as medically necessary. It was noted repairs were just authorized 3 months ago; clinical is insufficient for which to base decision; no way of knowing what is broken and what is required; rely on integrity of supplier; currently in position to possibly certify non essential items as situation exists at present; unable to certify under ODG. A reconsideration review dated 12/06/11 noted non-authorization of reconsideration request based on clinical information available. It was noted that the claimant had a power mobility device since 04/01/08. Several repairs have been made to the chair. No clinical records were provided for review. The only notes provided are two receipts of chairs made to existing PMD.

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

Based on the limited clinical information provided, medical necessity cannot be established for proposed DME power wheelchair repairs. The claimant is noted to have sustained injury in xxxx. He has history of C7 ASIA-B spinal cord injury. Records indicate the claimant has had power mobility device (PMD) since 04/01/08 and several repairs have been made to the chair. There are no detailed clinical records provided indicating the need for repairs. It is noted that repairs were authorized just 3 months ago. It was unclear at this point in time what repairs have been completed as previously authorized, and what additional repairs are needed at this time. The reviewer finds no medical necessity for DME Power Wheel Chair Repairs.

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

ACOEM-AMERICA 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)