



**MEDICAL EVALUATORS  
OF TEXAS** ASO, L.L.C.

1225 North Loop West • Suite 1055 • Houston, TX 77008  
800-845-8982 FAX: 713-583-5943

**Notice of Independent Review Decision**

**DATE OF REVIEW:** May 31, 2012

**IRO CASE #:**

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

*Replacement power wheel chair*

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

A physician that is board certified in Orthopaedic Surgery and is currently practicing in the state of Texas.

**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**

<b>Type of Document Received</b>	<b>Date(s) of Record</b>
A quote from Products Corp.	02/21/2007
A letter from from	03/01/2007
A progress note from Dr., M.D.	04/12/2011
A progress note from Dr., M.D.	09/13/2011
A progress note from Dr., M.D.	01/12/2012
A progress note from Dr., M.D.	04/19/2012
A letter from Dr., M.D.	04/19/2012
A utilization review determination from Inc.	04/24/2012
A utilization review determination from, Inc.	05/15/2012



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Request for review by IRO for the denied service(s) of replacement power wheel chair	05/16/2012

**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This is a male who fell off ladder at work on and sustained injury to his neck lower back resulting in spinal cord injury with paralysis of both lower extremities and atonic bladder. He was evaluated and treated by Dr., M.D. The patient uses power wheel chair for mobilization and lives in rural area and is requesting a replacement of power wheel chair which is denied.

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

Based on the clinical records of a T4 cord transaction, a motorized wheelchair is appropriate. At this level, the trunk muscles are paralyzed. The result is that the patient cannot stabilize his trunk in order to get optimum use of the arms to power a regular wheelchair.

ODG guidelines support medical necessity for the requested motorized wheelchair. Prior to replacement of the current motorized wheelchair, documentation should be provided indicating that the current wheelchair is defective or poorly operable.

**ODG INDICATION FOR POWER MOBILITY DEVICES (PMDS)**

Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient 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. (CMS, 2006) 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. See also Immobilization.



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

- ACOEM- AMERICAN 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)