

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** May 17, 2012

**IRO CASE #:**

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

Purchase of a Power Wheel Chair, K0848, E2361, E2300, E1028, E2310, K0108, E2620, E0973, E0995, E2624

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

This physician is Board Certified in Occupational Medicine with over 34 years of experience.

**REVIEW OUTCOME:**

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

04/19/11: Anesthesiology Progress Note by  
04/20/11: Anesthesiology Progress Note by  
05/20/11: History and Physical Examination by  
05/31/11: PICC Line Insertion Interpreted by  
07/07/11: Discharge Summary by  
07/21/11: Initial Visit by  
08/04/11: Consultation by  
08/12/11: Discharge Summary by  
04/06/12: UR performed by  
04/11/12: Examination Findings by  
04/18/12: Letter of Medical Necessity by  
04/27/12: UR performed by

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant is a female who sustained a T7 fracture and paraplegia on xxxxx when she sustained a work-related motor vehicle accident when her brakes reportedly failed. She is status post T3 to T12 posterior arthrodesis and full-thickness gluteal flap reconstruction, coccyx amputation and debridement of sacrum.

05/20/11: The claimant was evaluated by for comprehensive rehabilitation. On examination of the extremities, overall tone was not increased. She had lower extremity atrophy and trace edema. She had full upper body range of motion. Motor testing revealed strength graded as 4 at the deltoid, 5 at the elbow, 4 at the wrist extensors and finger flexion, and 3 at the hand intrinsics. DTRs were 2+ at the upper extremities. Rehab goals were to reach a level of modified independence for bed mobility, functional transfers, wheelchair propulsion, and activities of daily living. Anticipated discharge was home with family support. Coverage stops when further progress toward the established goals is unlikely or further progress can be achieved in a less intensive setting.

07/07/11: The claimant was discharged from noted that she was getting to the level of modified independence with upper and lower body dressing as well as wheelchair mobility and transfers. She still had difficulty with transferring from a lower to a higher surface, even with assistance of sliding board.

07/21/11: The claimant was evaluated by under the supervision of who indicated that she complained of overall body pain. She was noted to be extremely depressed and had high levels of anxiety. On physical examination, her VAS was reported as 6/10 with medications on board. Cervical spine ROM was decreased in all directions with pain at each end range. She was to return in two weeks.

04/06/12: UR performed by. Reviewer Comments: The patient is status post MVA and has paraplegia. She also has chronic pain. The progress note dated 11/29/11 indicates that the patient is wheelchair-bound. She has no control of bowel or bladder. Her legs are defunct. Cervical spine has full range of motion with muscle spasms of paravertebral muscles. X-ray of the cervical spine did not reveal any abnormalities. A recent power mobility device evaluation questionnaire indicates that she is unable to use her arms due to weakness as a result of cervical spine injury. A request for a powered wheelchair has been made. However, it appears that the patient is already using a wheelchair. Hence, I am uncertain about the necessity of purchasing a new wheelchair. Also, there is no recent evaluation by the provider, focusing particularly on her arm strength including grip strength. The necessity of the request is not established.

04/11/12: The claimant was examined by who noted that she continued to complain of stiff, dull, achy, sometimes sharp upper back pain, which radiates

into bilateral scapulae, right worse than left. She stated that she felt a sharp, sticking pain around her right scapula, which was fractured during the accident. The pain was made worse on attempting to raise her right arm above shoulder level. She had a cyst on her left elbow that was traumatic and had not been previously addressed until the month of February of 2012 with the orthopedic surgeon, draining the cyst twice. She had to remove the arm bars from her wheelchair, as resting the left elbow upon them just worsened her discomfort. On physical examination, her right shoulder was tender to palpation over the right trapezius, the AC joint, and anteriorly just beneath the acromion. She had 2/4 myospasm and deformity of her right shoulder girdle as a consequence of thoracoscapsular myofascial component. She could abduct the right shoulder to 130 degrees, flex to 145 degrees, internally rotate to 80 degrees, and externally rotate to 70 degrees. She had positive Neer impingement test. Her left shoulder could be abducted to 160 degrees, flexed to 170 degrees, internally rotated to 80 degrees, internally rotated 80 degrees, and externally rotated to 75 degrees. She could rotate her cervical spine to the right to 65 degrees, to the left to 65 degrees, flex to 35 degrees, and extend to 40 degrees. PLAN: Would at this juncture like to address her right shoulder with the patient having sustained a fractured right scapula and possessing an impingement syndrome postsurgically following her T3 through T12 posterior arthrodesis. So would like an MRI of her right shoulder.

04/18/12: Letter of Medical Necessity by She has previously developed sacral decubiti requiring a full-thickness gluteal flap rotational reconstruction, amputation of her coccyx, and debridement of her sacrum due to the development of osteomyelitis in association with the ulceration. She now has some desquamation of tissue at her right buttock as a consequence of pressure. She also has an issue with her right shoulder girdle having sustained a fractured right scapula and possessing postoperative T2 through T7 facet syndrome at her upper thoracic spine, right greater than left; thus producing a significant impingement of her right shoulder. For these two reasons, Ms. Shupe requires the use of a motorized power scooter. With respect to the ulceration at her right buttock, in order to minimize the length of time that she is seated in her current mechanical wheelchair, it must be remembered that the patient does shopping for the family, and as she is mobility impaired with respect to her right shoulder girdle sometimes must sit in her mechanical wheelchair for extended periods of time, and this has led to the initial redevelopment of a repeat decubital ulceration at her right buttock which is currently being attended to employing conservative measures. Secondly, readdressing her right shoulder impingement and shoulder girdle entrapment, a large degree of the patient's pain profile is a direct result of her thoracic facet syndrome on the right and she is presently employing the use of a Duragesic patch 100 mcg as well as Norco 10/325 mg five times daily on average for breakthrough pain. Her mechanical wheelchair only worsens her pain and thus elevates her opiate requirements. In essence, Ms. xxxx requires a motorized scooter for traversing long distances in order to reduce opioid need and serve as a preventative for decubitus ulceration.

04/27/12: UR performed by Reviewer's comments: The patient is paraplegic. The office note dated 4/18/12 states that the patient significant impingement in the right shoulder and develops repeated decubitus ulcerations on her right buttocks with use of a mechanical wheelchair. This previous wheelchair worsens the patient's pain and elevates her opiate requirements. The progress report dated 4/11/12 states that the patient has bilateral hip pain. The patient's right shoulder is tender over the right trapezius, acromioclavicular joint, and anteriorly beneath the acromion. The patient has myospasm and deformity of the right shoulder girdle. Neer's impingement test is positive. This is an appeal for purchase of a power wheelchair. The request was previously non-certified because the patient is already using a wheelchair and there is no recent documentation of a recent physical examination to describe the patient's arm and grip strength. Updated documentation states that the patient has difficulty on the right shoulder due to impingement. However, there is still no documentation of a comprehensive physical evaluation to include testing for the patient's arm and grip strengths. For the above reasons, the medical necessity of this request cannot be established at this time.

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

The prior adverse decisions are overturned. Examination findings by on 4/11/12 demonstrate bilateral shoulder impingement due to thoracoscapular myofascial components, right greater than left, as well as had 2/4 myospasm and deformity of her right shoulder girdle as a consequence of thoracoscapular myofascial component. ODG recommends that a patient have significant upper extremity function to propel a manual wheelchair, which she does not. Therefore, medical necessity for a power assisted device has been established, and I am endorsing this request for the purchase of a power wheelchair K0848, E2361, E2300, E1028, E2310, K0108, E2620, E0973, E0995, E2624.

ODG:

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. ( <a href="#">CMS, 2006</a> ) 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 <a href="#">Immobilization</a> .
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**IRO REVIEWER REPORT TEMPLATE -WC**

**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)