

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Wheelchair accessible vehicle

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

PM&R and Pain Medicine

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 06/03/11-01/29/13
Behind the wheel evaluation 11/19/12
Updated but undated recommendation note
Previous utilization reviews 04/10/13 and 04/29/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who required a wheelchair for ambulatory purposes. Clinical note dated 06/03/11 detailed the patient requesting a conversion for a wheelchair accessible vehicle. The patient required long distance traveling in order to meet his physical therapy at that time. The patient underwent successful training in order to operate power wheelchair and the entrance and exit requirements for a vehicle. Clinical note dated 04/30/12 detailed the patient undergoing an adaptation to his vehicle in order to meet the wheelchair frame needs and seating dimensions. The wheelchair was noted to have worn out. Electronics were malfunctioning and not operating consistently. Behind the wheel evaluation on 11/19/12 detailed the patient adequately meeting the necessary assessment for operating a vehicle. Utilization review dated 04/10/13 for a wheelchair accessible vehicle resulted in a denial as no documentation was submitted regarding the inability for the patient to utilize additional modes of transportation in relation to the powered wheelchair. Clinical utilization review dated 04/29/13 for a wheelchair accessible vehicle resulted in a denial as no information was submitted concerning the inability of the patient to utilize a different wheelchair.

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

Clinical documentation detailed the patient having difficulty as the patient had undergone the use of a new wheelchair. The new wheelchair has difficulty entering the current mode of transportation. A new wheelchair accessible vehicle would be indicated provided that the patient meets specific criteria, including the vehicle no longer functioning properly. However, the specific request is related to the wheelchair being unable to be utilized in the current vehicle. No information was submitted regarding the inability of the patient to utilize a different wheelchair that would be accessible to the current vehicle. Given that no information was submitted regarding the current status of the patient to be able to utilize a different wheelchair this request is not indicated as medically necessary. As such it is the opinion of the reviewer that the request for a wheelchair accessible vehicle is not recommended as medically necessary.

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)

Unicare Clinical Guidelines. Power Wheelchair Mobility Devices.