

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Wheelchair motor repair

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

Board Certified Orthopedic Surgeon

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 note dated 05/02/12

Clinical note dated 07/03/12

Clinical note dated 08/15/12

Clinical note dated 02/04/13

Clinical note dated 11/20/13

Adverse determinations dated 10/18/13 & 11/01/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has been diagnosed with gouty tophaceous lesions in the hand. The clinical note dated 05/02/12 indicates the patient having large tophaceous gout despite a previous surgical incision. The patient was noted to have good flexion and extension and a nicely healed incision at that time. The clinical note dated 07/03/12 mentions the patient continuing with complaints of severe gouty tophaceous lesions. The clinical note dated 08/15/12 indicates the patient presenting as a status post above the knee amputation. The note mentions the patient utilizing a motorized wheelchair. The note mentions the patient utilizing Celebrex for ongoing pain relief. The clinical note dated 02/04/13 mentions the patient presenting for an analysis and fixation of the motorized wheelchair which was noted to be breaking down. The clinical note dated 11/20/13 mentions the patient having a full thickness rotator cuff tear at the left shoulder along with severe tendinitis and impingement of the rotator cuff in the right shoulder as well as a labral tear.

The utilization review dated 10/18/13 resulted in a denial for a power wheelchair repair as no information was submitted regarding the patient's ability to utilize a manual wheelchair.

The utilization review dated 11/01/13 resulted in a denial for a wheelchair repair as it was unclear if the patient was able to have the upper body functionality to utilize a manual wheelchair.

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

The documentation submitted for review elaborates the patient being an above the knee amputee. Repairs for a motorized wheelchair would be indicated provided the patient meets specific criteria to include the patient noted to have an inability to utilize a manual wheelchair and the current wheelchair is noted to have previously been beneficial to the patient with subsequent need for repairs. There is mention in the clinical note regarding the patient's wheelchair currently breaking down. However, no specific details were provided. Additionally, there is mention in the clinical note regarding the patient's rotator cuff involvement in both shoulders. However, no imaging studies were submitted confirming the patient's clinical presentation confirming the shoulder injuries. Additionally, it is unclear if the patient is undergoing bilateral shoulder surgical interventions. Given these findings, the need for a motorized wheelchair has not been established. As such, it is the opinion of the reviewer that the request for a wheelchair motor repair is not indicated as medically necessary.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES