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Notice of Independent Review Decision

**December 28, 2013**

**IRO CASE #:**

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

Power scooter with lift FDR car

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

Board Certified Physical Medicine and Rehabilitation Physician

**REVIEW OUTCOME:**

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

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

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

- Utilization reviews (11/01/13, 12/03/13)
- Utilization reviews (11/01/13, 12/03/13)
- Office visits (11/26/13)
- Office visits (01/16/13 - 11/26/13)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who on xx/xx/xx, slipped and fell injuring her left leg.

**xxxx – 2012:** No records are available.

**2013:** On January 16, 2013, evaluated the patient for significant pain in the left lower extremity radiating into the knee. The pain was severe, constant and it occurred daily. The patient reported that overall she was doing fairly well. She was utilizing hydrocodone and fentanyl patch which was helping. She denied any adverse effect from the medications. Examination of the left knee showed decreased range of motion (ROM), extensive scarring and deformity of the left lower limb. Diagnosis was slip and fall incident dated xx/xx/xx, with resultant failure of the left femoral hardware. The patient had pre-existing left total knee arthroplasty (TKA) as well as left femur fracture. The other diagnoses were hypertension, hepatitis A and allergy to morphine. prescribed Neurontin and recommended continuing fentanyl patch.

On February 14, 2013, noted that the patient still had moderate-to-severe, constant, sharp, burning and throbbing left leg pain. The patient felt that fentanyl and hydrocodone were helpful to improve pain and functional level. The patient was independent with walking and self-care and did not drive. prescribed fentanyl patch and Skelaxin and recommended follow-up in four weeks.

On March 13, 2013, the patient reported that she was doing essentially the same. She complained of left knee pain which was severe, constant and daily. Her pain level was 7-9/10 and it was described as sharp, throbbing and pressure-like in the knee. reviewed the laboratory tests date February 12, 2013. The patient was noted to have associated weakness and night symptoms. She was independent with walking and self-care. The patient had deformity at the left knee joint with lack of knee flexion. She had generalized diffuse tenderness about the knee and leg on the left. prescribed fentanyl patch and Lidoderm patch and recommended continuing Norco.

On April 8, 2013, noted that the patient was doing fairly well but she still continued to have left leg pain. The pain went from the thigh down to the ankle. The patient reported that sometimes her back hurt due to strain on the low back. Most of the time, her pain level was 6-7/10 and it was aching, stabbing, sharp, throbbing, dull and pressure-like. The pain radiated up to the back. She ambulated without assistive device within the room. She had poor knee flexion and extension; neither one were complete. She had deformity of the left knee, significant extensive scarring over the left knee and lower thigh. refilled hydrocodone, gabapentin, trazodone and Skelaxin and recommended continuing fentanyl patch.

On July 3, 2013, noted the patient continued to have hip and knee joint pain and left leg pain. The pain was worse with twisting, standing, walking and it was relieved by medications. She reported that the medications improved the ability to function and pain level. The pain was constant, shooting, sharp and pressure-like in nature. Her pain level was 7/10 with medications and 9/10 without medications. She was utilizing fentanyl and Lidoderm patches, Neurontin, Norco, Skelaxin and trazodone. It was noted that the patient was having no apparent problem with opiate regimen. The patient was tolerating the medications well and appeared to be using it appropriately as instructed. prescribed fentanyl patch and Neurontin and recommended rehabilitation.

On July 31, 2013, noted that the patient continued to have left leg pain. prescribed fentanyl patch and recommended rehabilitation. A urine drug screen was ordered.

On August 29, 2013, noted that after the last visit the patient had stopped her fentanyl patch suddenly. She had withdrawal signs and symptoms. She was tired of dealing with the insurance company threatening to not authorize them. noted the patient was treated for colitis in the hospital over the last month. The patient reported that Norco was not sufficient and her pain level was 9/10. reviewed the urine drug screen dated August 2, 2013, which showed abnormal level of hydrocodone, hydromorphone, fentanyl, norfentanyl and norhydrocodone. prescribed Percocet and scheduled rehabilitation therapy.

On September 25, 2013, noted that the patient continued to have left leg pain. The patient reported that Percocet helped with the pain and she wanted to stay with it. maintained her Percocet and recommended rehab.

On October 29, 2013, the patient reported having an extraordinary pain with any distance walking. She had been to an art fair over the weekend. She still had severe pain on the left leg. recommended decreasing the dose of Percocet and a trial of OxyContin. also ordered a power scooter for the patient because of inability to do any significant distance ambulation resulting in poor quality of living.

Per utilization review dated November 1, 2013, the request for power scooter with lift for car was denied with the following rationale: *"The request for a Power Scooter with lift for car, left knee/leg is not medically necessary. ODG in the knee chapter does not recommend PMDs or power mobility devices if the functional mobility deficit can be resolved by use of a cane or walker or the patient has sufficient upper body function to propel a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process. A PMD is not essential to care."*

On November 26, 2013, evaluated the patient for left leg, hip joint and knee pain. The pain was worse with twisting, standing, walking, sitting, bending and it was relieved with medications. The pain was sharp, shooting and pressure-like in nature. Her pain level without medication was 9/10 and with medication was 5-7/10. The patient reported that Percocet helped her pain but it was not sufficient. She tolerated it without any adverse effects. She took OxyContin that made her feel depressed. She reported having extraordinary pain with any distance walking. Examination showed deformity of the left knee, tenderness of the left knee, thigh, iliotibial band (ITB), upper calf, poor ROM of the left knee without gross instability. reviewed the laboratory tests and urine drug screen. The urine drug screen showed abnormal findings. prescribed Percocet and trazodone and opined that these medications were medically necessary due to the pain. The patient might need an increase in the medications the following month as the pain was not well controlled. The power chair was medically necessary as the patient could not ambulate any significant distance due to the left lower extremity pain.

She was noted to have visible deformity/scarring. The power chair could solve the distance problem. The patient could only walk less than 500 feet without extreme pain stopping her.

Per reconsideration review dated December 3, 2013, the request for power scooter with lift for car was denied with the following rationale: *“A Power Scooter with lift for car, left knee/leg is not medically necessary. ODG Guidelines for a power mobility device have not been met. ODG does not recommend power mobility devices if functional mobility deficits can be resolved with a cane, walker or manual wheelchair. Review of available medical records does not document why the claimant’s mobility deficit issues could not be resolved with a cane, a walker or an optimally-configured manual wheelchair. Supplied medical records do not document upper extremity deficits which could prevent manual wheelchair mobility. Therefore, a power scooter with lift for car, left knee/leg is not medically necessary.”*

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

Based on ODG Guidelines the request for a power scooter with lift is not medically necessary. The records reviewed do not support mobility deficits cannot be met by manual devices including cane, walker or manual wheelchair, which is required by ODG. Therefore, as per ODG the request is not medically necessary.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**