

US Decisions Inc.

An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

DATE NOTICE SENT TO ALL PARTIES: Nov/20/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 power wheelchair between 9/28/15 and 11/27/15

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Family 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. It is opinion of this reviewer the request for power wheelchair between 09/20/15 11/27/15 is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a XX year old female. 04/14/11, a peer review was performed and it was noted the diagnosis for this individual would be failed back, syndrome, chronic pain, post-laminectomy syndrome. Non-related diagnosis would include severe degenerative changes of the lumbar spine. On an unspecified date, a handwritten order was submitted for a power wheelchair for diagnosis of degenerative disease lengthening 99 months. On 07/28/15, the patient seen in clinic. A handwritten note was a poor copy quality. On 01/13/15, the patient seen in clinic and she had complaints of pain with radiation to her leg. On exam she stood 5'7" tall weighed 225 pounds. She was using a cane and she had 2+ patellar reflexes bilaterally, and she had good toe extension the right. Weakness was noted on a left and she had an absent Achilles reflex bilaterally.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 09/08/15, a utilization review letter for the requested power wheelchair was submitted, and criteria used was Official Disability Guidelines pain chapter for power mobility devices. It was noted these devices are not recommended if the functional mobility deficit could be sufficiently resolved by the prescription of a cane or walker, or if patient had sufficient upper extremity function to propel a manual wheelchair, or if there was a caregiver who was available, ready and able to provide assistance with a manual wheelchair. It was noted the patient does not have documentation of inadequate functional and or motor capacity of the upper extremities to propel a manual wheelchair and there was no clear interim history to support pathology in the upper extremities as it related to the XXXX injury, and there was no clear workup or treatment for that condition or complaints of upper extremity weakness or numbness. It was noted the patient's BMI of 35.2 would indicate that a cane or walker would support her.

On 10/05/15, a utilization review determination letter was submitted, citing Official Disability Guidelines pain chapter for power mobility devices. It was noted the request was non-certified, as there was no documentation that the patient did not have sufficient upper extremity function to propel a manual wheelchair, and there was no indication that the patient

did not have a caregiver who was available willing and able to provide assistance within manual wheelchair.

Official disability guidelines, pain chapter, in discussing power wheelchairs, states this device is 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. For this patient, there is inadequate documentation of the strength and functional capacity of the patient's upper extremities to warrant this device.

It is opinion of this reviewer the request for power wheelchair between 09/20/15 11/27/15 is not medically necessary and the prior denials are upheld.

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)