

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/13/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** purchase of lift chair

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Physical Medicine and Rehabilitation 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.** It is the opinion of the reviewer that the request for purchase of lift chair is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. On this date the patient was pinned between an ATM machine and big rig. Surgical history is noted to include neck surgery in 2000, left carpal tunnel release in 1997, bilateral inguinal hernia repair in 2000, and multiple lumbar surgeries in 1994 and 2001. Lumbar MRI dated 09/30/14 revealed multilevel small focal disc protrusions and degenerative disease from L1 to L4 causes minimal to mild anterior canal narrowing at those levels; mild subarticular zone stenosis at L4-5 secondary to facet spurs. There is also moderate bilateral neural foraminal narrowing at this level. There is previous laminectomy of the lower lumbar spine from the L4 level to the S2 level. There is a recurrent or residual small focal left subarticular zone disc osteophyte complex at L5-S1 which is slightly contacting traversing left S1 nerve roots. Progress note dated 02/04/15 indicates that the patient presents with chronic low back pain and left lower extremity neuropathy. The patient is doing well in regards to pain and is stable on medications. The patient is very painful when getting up out of chair and needs assistance greater than 50% of the time. Current medications include Fentanyl patch, metoprolol, lisinopril, simvastatin, Zetia, Nexium, Temazepam, gabapentin, methocarbamol, Lantus, Humalog, Lidoderm patch, Effexor, venlafaxine, tamsulosin and cefuroxime axetil. On physical examination the patient has difficulty getting up from a chair and falls back to sitting. Assessments note lumbago, depressive disorder not elsewhere classified, and unspecified retention of urine.

The initial request for purchase of lift chair was non-certified on 02/20/15 noting that there is no documentation of a focal neurological deficit on physical examination. Additionally, a past lumbar MRI did not appear to reveal any findings definitively worrisome for a compressive lesion upon a neural element in the lumbar spine. The denial was upheld on appeal dated 03/19/15 noting that there was no documentation of recent physical therapy or the use of any assistive device such as a walker or cane to aid in mobility.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries in 1991 and is noted to have a history of multiple surgeries. However, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no indication that the patient has undergone any recent active treatment. There is no documentation that the patient is incapable of standing up from a regular armchair. There is no documentation of severe arthritis of the hip or knee or severe neuromuscular disease. There is no indication that the patient utilizes any assistive devices for ambulation. Given the current clinical data, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for purchase of lift chair is not recommended as 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)