

True Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 06/07/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Pediatric Orthopedics And Orthopedic Surgery

Description of the service or services in dispute:

DME Scooter for lumbar spine

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)

Patient Clinical History (Summary)

The patient is a male diagnosed with low back pain for whom a DME scooter has been requested. His diagnostic testing has included electrodiagnostic studies on XX/XX/XX, which revealed evidence of bilateral L5-S1 radiculopathy, but no electrodiagnostic evidence of bilateral lower extremity peripheral neuropathy or lumbosacral plexopathy. Lumbar spine radiographs on XX/XX/XX, revealed an L5-S1 fusion with no significant radiographic abnormality. A CT of the lumbar spine on XX/XX/XX, revealed surgical changes at L5-S1; and moderate spinal canal stenosis is present at L3-4, which in large part was related to the patient's congenital/developmental spinal canal stenosis due to short pedicles. His other therapies have included medications (antidepressants, antiepileptics, and opioids), the use of a cane, the use of a wheelchair, a right sacroiliac joint injection on XX/XX/XX, a left sacroiliac joint injection on XX/XX/XX, and spinal cord stimulator. The provided documentation indicates that the patient was using a quad cane for ambulation assistance as of XX/XX/XX. He had ongoing progressive weakness in the lower extremities, but continued to use a quad cane for ambulation as of XX/XX/XX. Both of those notes also indicate that the patient was wheelchair bound; however, he was able to use the quad cane to ambulate. As of XX/XX/XX, the clinician again reported that the patient was able to use a quad cane for ambulation, but also documented that the patient was wheelchair bound. A personal mobility evaluation dated XX/XX/XX, was provided for review, and indicated that the onset of the patient's condition or injury occurred on XX/XX/XX. His diagnoses were noted to include lumbosacral spinal fusion with neurological complications, right lumbaric radiculopathy, bilateral sacroiliac pain, permanent spinal cord stimulator, and chronic fatigue. The patient's prognosis was described as degrading, as the patient reported worsening of his condition within the past 18 months following improvements from date of injury. The patient was able to ambulate short distances (approximately 30 feet maximum) with use of a cane, but fatigued quickly upon further ambulation. The patient was not bed or chair confined. The equipment being requested was a POV-GoGo Elite Traveller 4 Wheel. The document indicated that the patient was unable to functionally propel a manual wheelchair functional distances due to fatigue and chronic pain. There was no mention of whether a family member or caregiver was available to propel a manual wheelchaor. The patient would require power equipment to cover functional distances. Functional considerations for scooter

within the home indicated that the patient did not require mobility equipment for in home use and his home was not conducive to the use of a POV; however, the patient indicated that the equipment was primarily for use outside of the home. Range of motion in the lumbar spine was limited. Muscle strength was very limited with exertion. Upper extremity function was good, but the patient reported numbness in the upper extremities. Lower extremity function was poor as the patient fatigued quickly with ambulation. The patient was able to transfer independently. The patient was able to perform pressure relief. The patient did not require any special seating. The patient was continent of bowel and bladder. The document indicated that the patient did not have moderate strength and tone resulting in an inability to maintain functional or symmetrical postures. The patient did not have a dislocated hip with a leg discrepancy of less than 2 inches. The patient did not have fixed contractures of the hips or knees that could not be accommodated by standard components. The patient did not have feet that could not maintain a plant grade position. The patient did not have hyper or hypotonia that prevented him or her from obtaining or maintaining symmetrical postures. The patient did not have fixed curvature of the spine that required custom molded seating. The patient was able to ambulate short distances with the use of a quad cane, and the requested equipment was for longer distances outside of the home, as well as for performance of MRADLs as needed outside of the home. No major contraindications to the use of a POV were noted. The patient did have the physical ability to operate a scooter but did not have the physical ability to operate a manual wheelchair. The patient did have the physical and mental ability to safely operate a power wheelchair. His head control was excellent. His upper extremity functioning was good, though the patient reported mild numbness in the upper extremities. His steering and directionally steering skills were excellent. His visual/spatial perception was good (he wore corrective lenses). The patient's safety mobility skills and cognitive level were described as excellent. Patient and home measurements were provided. The patient was noted to live in a first floor apartment with access to all major living areas, and no modification's should be necessary to allow for access; however, the patient had been advised that addition of ramps may be needed for ingress and egress if equipment is needed indoors in the future.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Current standards of care support the coverage of equipment of appropriate type and complexity to restore the patient's ability to participate in mobility related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. The provided documentation does not indicate that this patient has a mobility limitation that significantly impairs his ability to participate in 1 or more mobility related activities of daily living in the home. The documentation indicates that the patient does not require mobility equipment for in home use, and the requested scooter would not be used in the home, but was primarily requested for use outside of the home. Additionally, the provided documentation indicated that the patient was unable to use a manual wheelchair due to fatigue, and patient reports of numbness in the upper extremities; however, the provided documentation did not include recent physical examination findings to include motor strength testing of the upper extremities or a trial demonstration with use of a manual wheelchair. Without evidence of mobility related activities of daily living impairment with regard to toileting, feeding, dressing, grooming, and/or bathing, the requested scooter is not supported. Based on the above information, the requested DME scooter for lumbar spine is not in accordance with generally accepted standards of medical practice or clinically appropriate in terms of type. As such, the requested DME scooter for lumbar spine is not medically necessary and the prior adverse determination should be upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of
- Chronic Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability
- Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)

REFERENCES:

Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3). Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=219&ncdver=2&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=mobility&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAABAAAAAAA%3d%3d&>

Centers for Medicare and Medicaid Services. Clinical Criteria for MAE Coverage. Retrieved from <https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/downloads/MAEAlgorithm.pdf>.

- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)