

P-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW: JULY 5, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Three new replacement sockets on current prosthesis and new prosthetic workout arm to the left upper extremity and supplies as an outpatient procedure.

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

Doctor of Medicine (M.D.)
Board Certified in Orthopaedic Surgery
Fellowship Training in Hand & Upper Extremity Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 3/20/08 and 5/8/08
Medical Records from Dr. 1/29/08 and 3/20/08
Letter of Medical necessity 6/16/08
Letter 6/16/08 and 6/24/08
Case Notes: 3/7/08, 5/1/08, 6/4/08, 6/5/08
Letters: 11/14/07, 3/7/08, 4/16/08; Office Visits: 3/3/08 thru 6/20/08
Letter 6/18/08
Records from Dr. 2/28/00 thru 5/22/01
Orthotics 3/10/02 and 4/25/02

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient suffered extensive burns and upper extremity injuries. He has a left below the elbow amputation and a workout prosthesis. His right upper extremity is ankylosed and very dysfunctional. Therefore, his left upper extremity would be below elbow prosthesis is the most functional arm. He currently requires replacement of his workout prosthesis as well as component repairs of his primary prosthesis which is 3 1/2 years old. This has been denied by the insurance company as excessive.

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

After a careful review of all medical records, the Reviewer's medical assessment is that the request is medically reasonable and necessary. There is no evidence of excessive use of his prosthesis or any sort of unreasonable request from his prosthetists. Therefore, the requested services is medically necessary.

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

- ACOEM- AMERICAN 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)**