



**IRO# 5356**  
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**DATE OF REVIEW:** 06/25/2010

**IRO CASE #:**

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

IRO - Right foot carbon plate, arch supports, toe filler

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

**REVIEW OUTCOME:**

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

**Upheld**

<b>Health Care Service(s) in Dispute</b>	<b>CPT Codes</b>	<b>Date of Service(s)</b>	<b>Outcome of Independent Review</b>
IRO - Right foot carbon plate, arch supports, toe filler	L2360, L3020, L5000	-	<b>Upheld</b>

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

<b>No</b>	<b>Document Type</b>	<b>Provider or Sender</b>	<b>Page Count</b>	<b>Service Start Date</b>	<b>Service End Date</b>
1	IRO Request		18	06/07/2010	06/07/2010
2	IRO Carrier/URA Records		9	06/07/2010	06/07/2010

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient is a male with a date of injury of xx/xx/xx. The mechanism of injury is described as "...a blade from a forklift struck his right ankle...". On xx/xx/xx, the claimant apparently had irrigation and wound debridement with external fixation. On 6/13/09, an additional wound irrigation and debridement with pins was performed. A transmetatarsal amputation right foot was performed on 07/07/2009. The claimant appears to have attended 30 out of 40 hyperbaric treatments. There are no records of medications. Imaging studies were not provided for review. The current request is for right foot carbon plate L2360, arch supports L3020 and toe filler L5000. There is limited medical information submitted with this request for preauthorization.

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

There is insufficient clinical information provided with this request to preauthorize carbon foot plate, arch supports and toe filler. The current status of the wound is not documented. The level of the transmetatarsal amputation is not described. Most often extra depth shoes, toe filler and rocker bottom soles are sufficient to

permit ambulation with transmetatarsal amputation. The request for Right foot carbon plate, arch supports, and toe filler is not medically necessary.

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

**OFFICIAL DISABILITY GUIDELINES: ANKLE AND FOOT CHAPTER**

Prostheses (artificial limb): Recommended as indicated below. See the [Knee Chapter](#). A prosthesis is a fabricated substitute for a missing body part. Lower limb prostheses may include a number of components, such as prosthetic feet, ankles, knees, endoskeletal knee-shin systems, socket insertions and suspensions, lower limb-hip prostheses, limb-ankle prostheses, etc. See also [Microprocessor-controlled foot prostheses; Proprio-Foot](#) (Ossur); & [Tensegrity prosthetic foot](#).

**Criteria for the use of prostheses:**

A lower limb prosthesis may be considered medically necessary when:

1. The patient will reach or maintain a defined functional state within a reasonable period of time;
2. The patient is motivated to ambulate; and
3. The prosthesis is furnished incident to a physician's services or on a physician's order.

- 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)