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**IRO certificate #**

**Notice of Independent Review Decision**

**DATE OF REVIEW: 6/18/12**

**IRO CASE: #**

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

Partial hand thumb restoration IP joint amputation, CPT: L7499 to the right hand, Prosthesis; Surgical procedure duration: 5/02/12 to 7/02/12

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

**Board Certified in Orthopaedic Surgery**

**REVIEW OUTCOME**

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

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]**

Patient is a gentleman who suffered a traumatic amputation of the right thumb while at work. Patient underwent debridement and complete amputation through the distal phalanx apparently leaving a little bit of the distal phalanx. It appeared a rotational skin flap was also performed. Post-operatively, patient underwent routine post-operative care and physical therapy. A request for a cosmetic distal thumb tip prosthesis has been ordered for cosmetic appearance and social integration as per the patient's doctor. This has been denied twice by the insurance company based on medical necessity.

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

I agree with the benefit company's decision to deny the requested services. The rationale: Prosthetics after amputation serve many purposes some of which are psychological, however, opinions are inconsistent. This type of amputation does not require a cosmetic prosthesis and will not increase function of the hand and may somewhat hinder it. Therefore, based on medical necessity from a functional standpoint, as well as the ODG guidelines, a cosmetic prosthesis for the tip of the right thumb, is not medically reasonable or necessary at this time.

**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)