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Notice of Independent Review Decision

**Date notice sent to all parties: 8/12/13**

**IRO CASE #:**

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

DME-RT 3<sup>rd</sup> Partial Finger Custom Silicone Restoration Prosthesis-  
ProstheticRehab Coordination

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

Texas Licensed, Board Certified Family Medicine Physician

**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 of the health care services in dispute.

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

1. Notice of IRO Assignment
2. IRO Request Form LHL009
3. 6/18/13 and 7/22/13 Denial Letters
4. 4/17/13 office note

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant is s/p right middle finger phalanx amputation from the date of xx/xx/xx. He has undergone surgery to the digit and he has been treated with post-injury therapy and a work hardening program. His most recent office note of 4/17/13 revealed he has minimal pain in the right hand. He completed a Functional Capacity Evaluation on 4/11/13 and he could lift up to 50 pounds occasionally with limited motion of the right DIP and PIP at 0%. The note is a bit confusing since it suggests the patient has an ankylosis of the right middle finger PIP and DIP joint at 0% but a review of prior records suggests the claimant had an amputation of the middle finger at the PIP joint which would suggest there are no joints to assess motion at PIP and DIP regions of the right middle finger. Never the less, there is no documentation of how the patient will reach a defined function state within a reasonable time. In fact, the records indicate the patient has reached a static and stable end treatment point with permanent disability.

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

The prior denial is upheld. Based on the ODG which states:

A 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 learn to use the limb; and
3. The prosthesis is furnished incident to a physician's services or on a physician's order as a substitute for a missing body part. (BlueCross BlueShield, 200)

In this case, the patient has no definable ability to improve his functional state. Therefore, the requested prosthesis has not met medical necessity.

**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)