

# IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: [imeddallas@msn.com](mailto:imeddallas@msn.com)

## Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**08/01/2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Reconsideration of Forte's NON-AUTHORIZATION of purchase of one (1) right partial hand electric prosthesis

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

Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

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

Upheld (Agree)

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:**

Clinical notes 08/19/12-05/06/13  
Operative report 08/19/12  
Previous utilization reviews 04/26/13 and 06/05/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury to his right hand when it was involved in an incident resulting in right hand degloving. The patient was initially treated with a wrist block and then transferred for surgical intervention. Surgical note dated 08/19/12 detailed the patient undergoing amputation of the right index finger at the MCP joint, amputation of the right long finger at the MCP joint, amputation of the right ring finger through the proximal phalanx, and amputation of the right small finger through the proximal phalanx. The patient also underwent irrigation and debridement of the right open fracture of the hand including the ring and small fingers and the hand itself. Clinical note dated 08/21/12

detailed the patient instructed to keep the right upper extremity elevated and padded. The clinical note dated 08/19/12 detailed the patient remaining in house for pain control and use of IV antibiotics secondary to the traumatic amputations. Clinical note dated 09/11/12 detailed the patient discharged and provided with a PCP for ongoing care. Procedure note dated 04/08/13 detailed the patient undergoing revision of the right fifth digit stump. Previous utilization review dated 04/26/13 resulted in a denial for a right partial hand electric prosthesis as no medical documentation was submitted from a medical perspective regarding the current expectations for the use of electric prosthetic device. Previous utilization review dated 06/05/13 for the use of an electric prosthetic device at the right hand resulted in a denial secondary to a lack of rationale supporting medical necessity.

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

Clinical documentation submitted for review notes the patient undergoing traumatic amputations of the fingers of the right hand. The use of electric prosthetic device would be indicated the patient meets specific criteria, including the establishment of the medical necessity for a prosthetic device in order to meet functional demands. No information or medical information was submitted regarding current functional deficits that would be alleviated with the use of an electric prosthetic device. Additionally, no information was submitted regarding completion of all conservative measures addressing functional deficits including the use of an electric prosthetic device. Given that no information was submitted regarding functional deficits indicating the medical necessity for electric prosthetic device this request is not indicated. As such it is the recommendation of this reviewer that the request for a right partial hand electric prosthetic device is not recommended as medically necessary.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Prostheses (artificial limbs)

Criteria for the use of prostheses:

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, 2004)