

Notice of Independent Review Decision

**CORRECTED REPORT  
DATE OMITTED FROM PAGE 2**

**DATE OF REVIEW:** 03/10/08

**IRO CASE #:**

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

Repeat MRI scan of the right wrist.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Orthopedic Surgery, fellowship-trained in Hand and Upper Extremity Surgery

**REVIEW OUTCOME:**

"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
842	73221	NA	Prosp	1					Upheld

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI Case Assignment
2. Letters of Denial, 01/29/08 and 02/21/08 with additional correspondence and criteria used in denial (ODG)
3. Radiology reports, 10/11/06
4. Designated Doctor Evaluation, 02/22/07
5. Peer Review, 05/04/07 and physician's response (undated)
6. DEC Evaluation, 01/08/07
7. Isometric Strength Assessment, 01/08/07
8. EMG nerve conduction study, 07/19/06
9. RME, 01/22/07
10. Orthopedic evaluation, DDE exam, 05/31/07
11. Treating doctor evaluations and office visits, 03/01/06 through 07/05/07
12. Orthopedic evaluation and follow-ups, 08/21/06 through 08/08/07

**SUMMARY OF INJURED EMPLOYEE CLINICAL HISTORY:**

The patient in questions has a long history of bilateral wrist pain due to repetitive overuse-type syndrome. The patient was given a diagnosis of carpal tunnel syndrome, dorsal wrist syndrome, as well as first extensor tendinitis. There really is not very good documentation of conservative treatment. However, there was a certain level of physical therapy and activity modifications. The patient continued to have symptoms and was referred from to the orthopedist. The patient was then referred to the hand surgeon. When he was initially seen on 02/14/07, he was just sent for a second opinion. It does not appear that any significant treatment was started. He returned on 06/04/07, and his symptoms continued in both wrists, right greater than left, with inadvertent paresthesias.

At that point the physician discussed extensively a Peer Review performed by the URA. He did not really give the patient any treatment at that time and recommended re-examination in a few months. At that time his diagnosis was radial tunnel syndrome, tendinopathy at the FCR, EPB, and APL, trapeziometacarpal joint arthropathy, and dorsal wrist syndrome. He was seen back on 08/08/07 with continued symptoms. He was placed on activity limitations. There was no other active treatment involved at that time.

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

The patient has chronic dorsal wrist syndrome, i.e., dorsal capsule synovitis as well as some tendinitis in his wrist. He has already had two MRI scans. The first two were performed only a month apart, which really has no diagnostic purpose. Regardless, the patient has some radiocarpal arthritis, which certainly could cause a lot of symptoms, i.e. dorsal wrist syndrome.

At this point, as recommended by the orthopedist, the patient would benefit from a diagnostic and/or possibly therapeutic arthroscopy of his wrist. This would certainly be able to better evaluate his intercarpal ligaments as well as the level of radiocarpal arthrosis that he has as a possible cause for his chronic wrist pain. It does not appear, or is not documented that he has had an injection of steroid into the radiocarpal joint. Regardless, a third MRI scan is of no use in this patient and does not meet the ODG criteria for advanced imaging. This decision does not diverge from the ODG criteria, and these were used as a clinical basis to make the decision as well as medical judgment and clinical expertise.

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

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
  - AHCPH-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 judgment, 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 national accepted medical literature (provide a description).
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\_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)