

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** November 12, 2009

**IRO CASE #:**

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

MRI of the left wrist and physical therapy for the left hand to include CPT code # 25246, 77002, 72132.

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

Diplomate, American Board of Orthopaedic Surgery

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Medical records from the URA include:

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Medical records from the Requestor/Provider include:

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### **PATIENT CLINICAL HISTORY:**

I have had the opportunity to review medical records on this patient. The records indicate that the IRO is requested regarding the medical necessity of a CT scan of the lumbar spine, arthrogram, and fluoroscopy of the left wrist and physical therapy of the left wrist.

The patient has been treated by M.D. His initial note is dated. He noted the patient slipped and fell and had radial wrist pain. An injection was performed at that time.

In his follow-up note of March 11, 2009, he reports that the patient has de Quervain's stenosing tenosynovitis and had an injection in the first dorsal compartment, affording her excellent relief. At that time, there was tenderness of the first dorsal compartment and no evidence of any ulnar-sided pain. A second injection was performed. He again notes excellent anesthetic phase relief following the injection. De Quervain's surgery was subsequently recommended and performed. The surgery was performed on May 18, 2009.

The patient returned to Dr. in June of 2009 without signs of infection and minimal pain. He recommended a slow return to normal activity.

Therapy was then prescribed on July 3, 2009. There was no evidence of subluxation. The wound had healed nicely.

The patient then returned to Dr. on August 5, 2009. He noted near complete relief of the pain along the first dorsal compartment. For the first time she complained of pain on the ulnar aspect of the wrist. He noted pain over the triangular fibrocartilage complex with ulnar grind. He recommended an MRI arthrogram. This was declined by the carrier.

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

respect to ODG Guidelines, the guidelines do not support the need for MRI for suspected TFCC tears. See below:

#### **Indications for imaging -- Magnetic resonance imaging (MRI):**

- Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required

- Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required

- Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury)
- Chronic wrist pain, plain films normal, suspect soft tissue tumor
- Chronic wrist pain, plain film normal or equivocal, suspect Kienböck's disease

Regarding the CPT code of 72132, this is a CT scan of the lumbar spine. There is no evidence in the records provided to me that any medical necessity exists with respect to a CT scan of the lumbar spine.

With regard to physical therapy for the left hand, ODG supports the need for a total of 14 physical therapy visits over a 12 week period following the surgery. It appears that the patient has already had the appropriate amount of postoperative physical therapy. Therefore, the denial is upheld for additional physical therapy.

**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)**