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88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

Notice of Independent Review Decision

DATE OF REVIEW:
01/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI of the left wrist without contrast and MRI of the right wrist without contrast

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

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.
The medical necessity for the application of MRI to the left and right wrists without contrast is not established.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 12/17/09 xxxxx Referral
- 12/17/09 Notice of Assignment of Independent Review Organization, DWC
- 12/17/09 Notice To Utilization Review Agent Of Assignment, DWC
- 12/17/09 Notice To, xxxxx Of Case Assignment, DWC
- 12/16/09 Confirmation of Receipt of a Request for a Review, DWC
- 12/15/09 Request For a Review By An Independent Review Organization
- 12/11/09 letter from
- 12/11/09 Appeal report, DC, xxxxx
- 11/17/09 letter from
- 11/16/09 Pre-Authorization report, DC, xxxxx
- 11/11/09, 12/08/09 Facsimile Transmittal Sheet authorization request, xxxxx
- 10/26/09 EMG/NCV studies report, Diagnostics
- 10/20/09 Notice of Independent Review Decision, Secretary/General Counsel,
- 9/30/09 Confirmation of Receipt of a Request For a Review, DWC
- 09/21/09, 08/24/09 Patient Re-Evaluation, M.D., PhD
- 08/24/09, 11/24/09 Patient Re-examination, D.C., xxxxx
- 08/10/09 Initial Evaluation, M.D., PhD
- 07/15/09 Initial Consultation, D.C., xxxxx

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- 06/26/09, 05/08/09 handwritten chart notes, M.D.
- Undated Request Form
- Undated, incomplete patient information form,xxxxx
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:
Records indicate that the above captioned individual is a female who presented to the office of the attending provider (AP) with bilateral wrist pain as well as numbness and tingling of the bilateral upper extremities that allegedly occurred as a result of an occupational incident. Serial physical examinations revealed positive orthopedic and neurologic testing consistent with the working diagnosis of carpal tunnel syndrome. To date, the injured individual has participated in a litany of treatment to include chiropractic management, medication management, injections, and physical therapy. Neurodiagnostic testing revealed evidence of carpal tunnel syndrome bilaterally. Electromyogram (EMG) testing was within normal limits. MRI examinations of the bilateral wrists have been requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The documentation fails to establish the medical necessity for the requested procedure(s), MRI to the bilateral wrists, for the purpose of differentially diagnosing a suspected carpal tunnel syndrome. Moreover, the application of this procedure would be inconsistent with the applicable occupational treatment guidelines, which according to the Official Disability Guidelines (ODG) in regards to the application of MRI in cases of suspected Carpal Tunnel Syndrome (CTS) states:

> MRI is "*Not recommended in the absence of ambiguous electrodiagnostic studies. Electrodiagnostic studies are likely to remain the pivotal diagnostic examination in patients with suspected CTS for the foreseeable future, but MR imaging may contribute to the diagnosis of CTS for patients with ambiguous electrodiagnostic studies and clinical examinations.*"

It is unclear what information is to be gained with the application of this procedure given the positive results of the physical examinations and neurodiagnostic testing already performed to date. As such, given the positive results of the neurodiagnostic testing and consistent with the ODG guidelines as referenced above, the medical necessity of the above captioned and requested MRI is not established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:
ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES