AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 6, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of Left Wrist without contrast

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

This reviewer is a Board Certified Orthopedic Surgeon with over 40 years of experience.

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1/13/10: MRI of the left wrist was performed. Impression: Findings suggestive avascular necrosis of the proximal portion of the lunate.

1/27/10: Wrist X-Rays were performed. Impression: No definite fracture, Soft tissue injury, and Arthritic changes.

1/29/10: M.D. evaluated the claimant. Impression: Left wrist dorso-radial laceration.

2/12/10: M.D. evaluated the claimant.

4/28/10: M.D., an orthopedic surgeon, evaluated the claimant.

6/22/10: M.D., an orthopedic surgeon, re-evaluated the claimant.

6/27/11: M.D. performed an UR on the claimant. Rationale for Denial: No true pathological or specific orthopedic indication for the requested MRI.

7/6/11: M.D. performed an UR on the claimant. Rationale for Denial: There is no clinical documentation to justify request.

PATIENT CLINICAL HISTORY:

The claimant sustained a laceration injury, when a broken mirror fell onto his radial wrist region.

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

The previous decisions are overturned. Per the ODG a repeat MRI is indicated if there are significant changes in symptoms. Per the medical records provided the claimant demonstrates increase in stiffness, swelling, difficulty moving his fingers, and weakness. Due to the significant changes in symptoms a repeat MRI of the wrist is medically reasonable and necessary.

Per the ODG:

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
- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)

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)