

Notice of Independent Review Decision

**DATE OF REVIEW:** 01/28/2011

**IRO CASE #:**

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

Prospective preauthorization review for MRI, CPT code 73221, any joint of upper extremity

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

**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.

Based on review of the available medical as noted above and noting that the patient had been diagnosed at the time of arthroscopy with a TFCC tear, repaired successfully, resolution of pain, and return to work, only to have subsequent return of symptoms like she had prior to the time of her arthroscopy. The IRO review would recommend that the original denial of the MRI/arthrogram of the wrist be overturned and that the treating doctor's request for diagnostic imaging in light of return of same or similar symptoms be approved.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the above medical records, this individual sustained a lifting type of injury involving the left wrist. While working for a, she was lifting an 80-pound piece of ground meat with resultant onset of pain. The MRI reports from 02/18/10 indicated the presence of MRI abnormalities consistent with a ligamentous TFCC tear, which was unresponsive to nonsurgical treatment. Surgery with left wrist arthroscopy 04/06/10 was performed with patient follow-up at the Group. Patient was released 07/26/10 noting that she was fully functional and capable of using her hand and wrist without problem.

The records seem to reflect that the patient was returned to work and underwent a designated doctor examination with maximum medical improvement 07/09/10 and a 3% whole person impairment rating based on limited range of motion.

The patient on 12/13/10 was seen by M.D., orthopedist, noting that the reason for requesting an MRI/arthrogram was that the patient's symptoms had returned to the same symptoms as before surgery. There was a possibility of extension of the original TFCC tear, and an MRI/arthrogram was necessary to evaluate the possible diagnosis

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

Based on review of the available medical as noted above and noting that the patient had been diagnosed at the time of arthroscopy with a TFCC tear, repaired successfully, resolution of pain, and return to work, only to have subsequent return of symptoms like she had prior to the time of her arthroscopy. The IRO review would recommend that the original denial of the MRI/arthrogram of the wrist be overturned and that the treating doctor's request for diagnostic imaging in light of return of same or similar symptoms be approved.

The *ODG* for both treatment of wrist symptoms as well as for imaging study reasonable and necessary. The MRI may have benefit in situations where there is a possibility of a past ligamentous tear, surgery, and return of same or similar symptoms. The only other approach would be for an absolute diagnostic test, which would be a repeat arthroscopy. It would appear appropriate to attempt to verify prior to any surgical procedure the diagnostic MRI.

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## **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

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- 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)

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