

SENT VIA EMAIL OR FAX ON
Feb/08/2011

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI left wrist

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

AADEP Certified
Whole Person Certified
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Chiropractor Physician
Clinical practice 10+ years in Chiropractic WC WH Therapy

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

OD Guidelines
Healthcare 12/27/10 and 1/18/11
Dr. 1/17/11
MRI 7/16/10
1/4/11 and 1/13/11
Clinic 5/3/10 thru 11/16/10
Bone and Joint 6/8/10 thru 12/2/10
PT Notes 6/21/10 thru 12/23/10
Report of Medical Eval 7/21/10
Pain and Injury 12/29/10

PATIENT CLINICAL HISTORY SUMMARY

The injured worker was injured on xx/xx/xx. The injured employee was seen on May 5, 2010 by MD who performed an examination, took x-rays and prescribed medication. On 6/08/2010

the injured worker was seen at Bone & Joint by MD and underwent a shoulder injection and placed into physical therapy. Dr. documented a full thickness tear in the left shoulder and recommended surgery. On 8/23/2010 the injured worker had a rotator cuff surgery on the left shoulder and was advised to have left knee surgery, which was declined. The injured employee underwent postoperative physical therapy. On 12/02/2010 Dr. reported in his notes that the injured employee was having decreases neurological sensation to the left hand and prescribed Neurontin. On 12/2/2010, Dr. diagnosed her with complex regional pain syndrome (CRPS) and recommended a referral to pain management for pain injections. The injured employee has undergone MRI, FCE, medication, injections, surgery, pre & postoperative physical therapy. The injured employee sought treatment with Dr. on 12/29/2010. She has been seen by another orthopedic surgeon Dr. MD on 1/17/201, who has recommended additional diagnostics. The injured worker continues to experience decreased ROM by about 40% in the left wrist. The injured worker continues to experience ongoing pain with decreased ROM and muscle strength; therefore, an MRI of the left wrist is now being requested by the treating physician. It is noted that the injured employee was seen by MD on 7/21/2010 and her determined that the injured employees condition was not stable and therefore was not at MMI.

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

The injured employee does meet the ODG criteria for a MRI of the left wrist. The injured employee has undergone pharmaceutical management, surgery to the shoulder, and physical theory. The injured employee continued to have ongoing symptoms that appear to have been progressive. She has decrease in ROM, pain, and muscle weakness. The treating physician recommends an MRI of the wrist to rule-out internal derangement of the wrist. ODG recommends MRI for chronic pain and findings suggestive of pathology.

ODG Guidelines:

	<p>Recommended as indicated below. While criteria for which patients may benefit from the addition of MRI have not been established, in selected cases where there is a high clinical suspicion of a fracture despite normal radiographs, MRI may prove useful. (ACR, 2001) (Schmitt, 2003) (Valeri, 1999) (Duer, 2007) Magnetic resonance imaging has been advocated for patients with chronic wrist pain because it enables clinicians to perform a global examination of the osseous and soft tissue structures. It may be diagnostic in patients with triangular fibrocartilage (TFC) and intraosseous ligament tears, occult fractures, avascular neurosis, and miscellaneous other abnormalities. Many articles dispute the value of imaging in the diagnosis of ligamentous tears, because arthroscopy may be more accurate and treatment can be performed along with the diagnosis. (Dalinka, 2000) (Tehranzadeh, 2006) For inflammatory arthritis, high-resolution in-office MRI with an average followup of 8 months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone erosions for this patient population in this time frame. (Chen, 2006) See also Radiography.</p> <p>Indications for imaging -- Magnetic resonance imaging (MRI):</p> <ul style="list-style-type: none"> - 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
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	<p>MCP ulnar collateral ligament injury)</p> <ul style="list-style-type: none"> - 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)
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM-AMERICA 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)