

SENT VIA EMAIL OR FAX ON  
Sep/27/2011

## True Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/27/2011

**IRO CASE #:**

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

MRI on 4/5/2011

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

Orthopedic 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**

OD Guidelines

1. Health insurance claim form
2. Bill review analysis 05/18/11
3. Bill review reevaluation 07/12/11
4. claims management independent review organization summary 08/17/11
5. Employer's first report of injury or illness
6. claims management notice of disputed issues and refusal to pay benefits
7. Associate statement/incident log form
8. Workers' Compensation request for medical care 12/06/10
9. Bonafide job offer-temporary alternative duty 12/09/10 and 02/25/11
10. Office notes Dr. MD 12/06/10 and 12/09/10
11. Physical therapy initial evaluation
12. Workers' Compensation initial evaluation report and progress reports DC 12/15/10 through 06/29/11
13. Functional capacity evaluation 01/31/11
14. Medical records/peer review MD 03/28/11
15. MRI left wrist 04/05/11
16. Designated doctor evaluation 08/05/11
17. Amendment to report
18. Electromyography report 07/26/11

## **PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a female whose date of injury is xx/xx/xx. The mechanism of injury has caused injury to the left hand/fingers and left elbow. She had subjective complaints of constant left wrist pain, hand throbbing, tingling, weakness and numbness. Examination on 12/15/10 reported normal deep tendon reflexes. Sensory examination noted areas of hypoesthesia within the dermatome areas corresponding to the C5, C6 nerve root on the left. Finklestein test was positive on the left producing slight pain. Tinel's sign was positive on the left. Right Phalen's sign was positive. Mill's test was positive. There was moderate left thenar tenderness to palpation, moderate extensor compartment left forearm tenderness. Left range of motion was decreased with pain. The injured employee was prescribed a course of conservative care including ultrasound and electrical stimulation as well as therapeutic exercise, trigger point therapy and cryotherapy. A functional capacity evaluation was performed on 01/31/11. Progress report dated 03/30/11 indicated the injured employee reported that her left hand and wrist was much improved. She has been working light duty which helped. She is able to resume daily ADLs without much difficulty like before. Objective findings reported mild level of discomfort found upon palpation of the left wrist, thenar. There was mild discomfort with palpation of the left forearm extensor compartment. There was mild tenderness of the left adductor opponens. Elbow flexors revealed mild tenderness. Left IP joint revealed mild tenderness. Evaluation of left adductor pollicis muscle area revealed a trigger point with active pain with radicular pain into the distal forearm region. Palpation of the dorsum surface of the left wrist muscle area revealed an active myofascial trigger point with radiating pain into the medial forearm region. There was increased range of motion in the left wrist. Manual motor testing reported left wrist flexion 5/5, extension 4/5, decreased sensation C5 dermatome, positive Cozen's test for lateral epicondylitis, decreased spasm noted, positive reverse Phalen's test, positive Finklestein's test for deQuervain's. Assessment was the injured employee has improved since last visit, able to return back to light duty, increased ADL activities and decreased symptoms. The injured employee was referred for MRI to rule out CTS versus deQuervain's. An MRI of the left wrist performed 04/05/11 reported two lobular fluid signal structures suspicious for ganglion cysts in the dorsal and volar aspect of the wrist. There was no contusion or occult fracture. TFCC is intact. Flexor and extensor tendons are intact. There is no evidence of tendinosis or tendon tear or tenosynovitis. Median nerve appears mildly enlarged in the carpal tunnel. Findings could represent median neuritis.

A bill review analysis dated 05/18/11 determined that MRI of the left wrist was unnecessary medical treatment based on peer review and based on extent of injury. The payment for MRI of the left wrist was denied because the treatment/service was medically unreasonable/unnecessary.

A reevaluation dated 07/12/11 determined the MRI of the left wrist to be unnecessary medical treatment based on peer review, original payment decision is being maintained as the claim was processed properly the first time. Denial also is based on extent of injury, charge unrelated to the compensable injury. Based on peer review, payment was denied because treatment/service was medically unreasonable/unnecessary.

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

The bill review analysis and reevaluation determinations were based on peer review. However, the patient has findings consistent with de Quervain's as well as possible carpal tunnel syndrome. The MRI of the left wrist was indicated as medically necessary to confirm/rule out carpal tunnel syndrome versus de Quervain's.

**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)