

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Sept/12/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Outpatient MR arthrogram of the left wrist

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D. Board Certified Orthopedic Surgeon

### 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

Peer Reviews: 08/01/11, 08/11/11

Official Disability Guidelines: Forearm, Wrist and Hand: MRI and Radiology

X-rays Report for left hand and wrist: 05/23/11

MRI of left wrist: 05/25/11

Dr. OV: 05/27/11, 06/14/11, 07/14/11, Letter of Appeal: 08/18/11

CT left upper extremity w/o contrast: 06/03/11

Occupational Therapy note: 06/21/11, 07/27/11

### PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his left hand and wrist on xx/xx/xxxx when he was hit on the left hand. X-rays on 05/23/11 of his left hand showed no obvious fracture, dislocation, bony, joint or soft tissue abnormalities. X-rays of his left wrist taken that same day showed an unfused ossified ossification at the center of the ulnar styloid process. There was irregularity of the lunate bone with soft tissue swelling in the dorsal aspect of the wrist, which needed further evaluation with an MRI. An MRI of the claimant's left wrist on 05/25/11 revealed extensive nonspecific subcutaneous edema around the wrist, particularly dorsally. There was no evidence of bone marrow contusion or acute fracture. There was an old ununited fracture of the ulnar styloid. There was a grade I strain/injury of the thenar musculature and minimal tenosynovitis of the second and fourth extensor compartment tendons. There was a mild amount of intrasubstance intermediate signal within the triangular fibrocartilage, compatible with mild degeneration or sequela of low-grade interstitial type injury. A CT scan of the claimant's left upper extremity without contrast on 06/03/11 revealed no acute fractures or dislocations of the wrist. There was either a remote ununited ulnar styloid avulsion or ununited ossification center. There was no evidence to suggest an acute lunate fracture. Dr. treated the claimant with a splint and occupational therapy. When the claimant saw Dr. on 07/14/11 he still had a lot of pain. Dr. was concerned that the claimant had a scapholunate ligament injury or a triangular fibrocartilage injury and recommended an MR arthrogram.

### ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

**AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The MRI obtained after the injury in question revealed only soft tissue contusion. There were no indirect findings of a more significant injury. The CT scan obtained after the injury similarly revealed no acute fracture. On overview this case has been evaluated by negative plain film imaging, a negative MRI, and a negative CT scan from a traumatic standpoint. Given all of this the medical necessity of Outpatient MR arthrogram of the left wrist cannot be supported under the guidelines. Very thorough imaging has already been conducted in this case to rule out any significant pathology. The reviewer finds no medical necessity for Outpatient MR arthrogram of the left wrist.

**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)