

**Notice of Independent Review Decision**

**DATE OF REVIEW: JANUARY 30, 2012**

**IRO CASE #:**

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

CPT: 73221 MRI of Right Hand

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

MD – Board Certified Orthopaedic Surgeon with over 30 years experience in Hand/Upper Extremity Trauma who has been licensed in the State of Texas since 1976.

**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**

| <b>Document Received</b>  | <b>Date(s) of Record</b> |
|---|--------------------------|
| Request for review by IRO for the denied service(s) of MRI any joint of upper extremity | 01-17-2012               |
| Reconsideration letter from Health Center   | 12-05-2011               |
| Amended Adverse determination letter  | 12-01-2011               |
| SOAP note from Health Center  | 11-21-2011               |
| Adverse determination letter from   | 12-27-2011               |
| Evaluation from Ortho   | 09-26-2011; 10-31-2011   |
| Treatment Plan from Health Center   | 11-21-2011               |
| FCE from Health   | 11-28-2011               |



|                        |                        |
|------------------------|------------------------|
| Progress note from Dr. | 11-30-2011             |
| Office note from D.C.  | 12-14-2011; 01-09-2012 |

**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work-related injury on or about xx/xx/xx to the right hand. The injured worker subsequently developed a right trigger ring finger, which is disputed as having been caused by the injury. The injured worker underwent a right ring finger trigger release on 9/14/11. The injured worker was seen in follow-up from surgery on September 26, 2011 by Dr.. The injured worker was doing well and was sent to therapy. On October 31, 2011, the injured worker was again seen by Dr.. She was doing better. A handwritten document is reviewed, dated November 21, 2011, in which a post surgical MRI is checked. A patient information sheet is included in the records provided. An order form for an open MRI of the right-hand is also included in the records provided, with a diagnosis of “post-op R ring finger”.

A document is present from the Health Center, Inc. Provider:, DC, dated 11/21/2011, which describes the date of injury as being on xx/xx/xx and the day of surgery as being 11/14/2011. This document extends for several (4) pages and has the appearance of a computer generated electronic medical record. The record contains the range of motion of the Finger 4 but does not include a comparison measurement of the other side. On the fourth page of this record an “MRI Post Surgical with Contrast Wrist/Hand to confirm or rule out a possible radiculopathy or neuromuscular injury” is mentioned.

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

After reviewing all information submitted, the proposed MRI: MRI right hand does not meet the medical necessity guidelines for the diagnosis of 736.1 (mallet finger)

ODG Indications for Imaging:

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)