MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ◆ Fax: 1-877-380-6702

Notice of Independent Review Decision

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ◆ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: December 30, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI of Right Wrist w/o Contrast.

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld	**(Agree)**
[ ] Overturned	(Disagree)
[ ] Partially Overturned	(Agree in part/Disagree in part)

The requested diagnostic procedure, Repeat MRI of Right Wrist w/o Contrast, is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 12/9/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/12/11.
3. Notice of Assignment of Independent Review Organization dated 12/12/11.
4. Hospital right wrist imaging report dated 10/26/11.
5. Hospital right wrist Forearm AP and Lat Right imaging dated 10/26/11.
6. Hospital MR right wrist without contrast dated 10/30/11.
7. Hospital Emergency Nursing Record dated 10/25/11.
8. Hospital Emergency Room Consultation dated 10/25/11.
9. Hospital Procedure Note dated 10/25/11.
10. Clinic notes dated 10/31/11.
11. Letter from MD dated 11/23/11.
12. Hospital Radiology report dated 12/11/11.
13. Denial letters dated 12/14/11, 12/2/11 and 11/21/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury to the right wrist on xx/xx/xx. The provider reports the patient's diagnosis code is 814.01, Closed Fracture of Navicular (Scaphoid). Conservative treatment included a wrist splint and medications. A right wrist arthrocentesis was also performed on 10/25/11. X-ray of the right wrist taken on 10/26/11 showed lucency of the right distal radial metaphysis which the provider noted was likely incidental and related to demineralization. A right wrist magnetic resonance imaging (MRI) scan dated 10/30/11 showed a non-displaced scaphoid wrist fracture with some soft tissue edema surrounding the fracture. The provider's notes of 10/31/11 described localized pain in the right wrist radial region. The examination also documented right wrist swelling, tenderness and decreased radial/ulnar bending. The diagnosis remained unchanged as fracture navicular wrist closed. A hand/wrist splint was applied and the patient was advised to follow-up in four weeks. At issue is whether the requested service, Repeat MRI of Right Wrist w/o Contrast, is medically necessary for treatment of the patient's medical condition.

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

On review of the patient's medical records and the Official Disability Guidelines (ODG), the requested MRI of the right wrist is not medically necessary for re-evaluation of this patient's fracture at this interval. The patient's wrist was recently imaged on MRI on 10/30/11; follow-up imaging can be assessed on non-MRI studies. The ODG state that MRI is useful in evaluating patients in selected cases where there is a high clinical suspicion of a fracture despite normal radiographs or when a global examination of soft tissue structures is indicated. In this patient's

case, a MRI was performed on 10/30/11 and there is no further indication for imaging as there is no evidence in the records of a significant change in symptoms and/or findings suggestive of significant pathology.

Therefore**,** I have determined the requested diagnostic procedure, Repeat MRI of Right Wrist w/o Contrast, is not medically necessary for treatment of the patient's medical condition.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)