

Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 836-9040
FAX: (512) 491-5145
IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 11/14/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI of Left Wrist, CPT: 73221

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Orthopaedic Surgery.

REVIEW OUTCOME

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

Upheld	(Agree)	X
Overtured	(Disagree)	
Partially Overtured	(Agree in part/Disagree in part)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

Patient sustained an injury, as reported, in xx/xxxx. The patient is a male who presented with wrist pain. The condition occurred following a specific injury after a fall. A previous MRI (1/29/13) was done showing a TFCC (triangular fibrocartilage complex) tear. Patient had wrist pain, swelling and decreased range of motion and described the pain as aching. Patient was treated with various modalities, including a wrist brace (3/05/13 office note). Current treatment (9/17/13 office note) includes wrist splint at night and nonsteroidal anti-inflammatory drugs (OTC Motrin). Apparently, a repeat MRI was requested and has been denied.

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

Decision

I agree with the benefit company's decision to deny the requested service.

Rationale:

I do not see a reason for a repeat MRI. This has already been done and diagnosis made. Treatment

decisions can be made on the response to his non surgical treatment and the previous MRI.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)