

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/02/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: repeat MRI with arthrogram of the right wrist

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The opinion of this reviewer that the request for MRI repeat MRI arthrogram of the right wrist is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his right wrist on xx/xx/xx. The MRI of the right wrist dated 05/02/13 revealed mild degenerative changes at the first carpal metacarpal joint. No tendon disruption was identified. A clinical note dated 05/13/13 indicated the patient continuing with pain at the dorsal aspect of the right wrist. Pain was identified at the right ring finger extensor and the MCP joint of the ring finger. The patient complained of severe levels of pain. The x-ray arthrogram of the right wrist dated 05/31/13 revealed findings consistent with synovitis. No evidence of TFCC or ligament tear was identified. X-rays of the right wrist dated 06/20/13 indicated the patient undergoing steroid injection which resulted in significant benefit. A clinical note dated 08/21/14 indicated the patient continuing with severe levels of pain at the snuff box of the right wrist. The patient was unable to perform any flexion/extension motions secondary to severe levels of pain. A clinical note dated 09/29/14 indicated the patient continuing with right wrist pain. A clinical note dated 11/12/14 indicated the patient complaining of 4-10/10 pain at the right wrist. The patient was recommended for repeat MRI. X-rays of the right wrist dated 11/12/00 utilization reviews dated 10/10/14 and 11/04/14 resulted in denials as insufficient information was submitted substantiating the need for repeat MRI arthrogram of the right wrist.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient complained of ongoing right wrist pain. The patient previously underwent arthrogram and MRI of the right wrist. Repeat studies are indicated provided that the patient meets specific criteria, including significant the development of significant pathology or new symptom or exacerbation of previously discovered symptomology have been confirmed. No information was submitted regarding significant developments of new pathology or ongoing symptomology that would likely benefit from a repeat imaging studies. Given this fact as such, the opinion of this reviewer that the request for MRI repeat MRI arthrogram of the right wrist is not recommended as medically

necessary and the prior denials are upheld.

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)