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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/07/2014

IRO CASE #:

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified General Surgery, Fellowship trained Hand and Upper Extremity 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. It is the opinion of this reviewer that the request for MR arthrogram of the left wrist is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her left wrist secondary to frequent use. Clinical note dated 12/28/11 indicated the patient complaining of bilateral thumb and index finger pain. The patient reported a catching of the index finger and thumb. The patient utilized anti-inflammatory medications and massage with no significant benefit. Procedure note dated 06/07/12 indicated the patient undergoing left carpal tunnel release. Clinical note dated 06/15/12 indicated the patient continuing with sharp pains along the radial side of the wrist with occasional throbbing. Operative report dated 07/19/12 indicated the patient undergoing right sided carpal tunnel release. Clinical note dated 10/26/12 indicated the patient reporting mild pain that was described as intermittent. The patient also described swelling and weakness at the right wrist. Clinical note dated 01/15/13 indicated the patient reporting numbness and tingling at the left wrist. Symptoms were more prevalent at the third throughout fifth digits. The patient had a positive Tinel sign over the cubital tunnel. Electrodiagnostic studies on 02/19/13 revealed prolonged peak latency with a slow conduction velocity at the right wrist. Clinical note dated 02/19/13 indicated the patient rating the pain as 2-8/10 and described it as burning, tingling, and discomfort in her hands. Clinical note dated 06/26/13 indicated the patient undergoing bracing, physical therapy, and non-steroidal medications. The patient continued with numbness and tingling with third through fifth digits of the left hand. Clinical note dated 10/15/13 indicated the patient complaining of intermittent flare up of symptoms. Tenderness was identified at the lateral wrist of the lateral side of both wrists. Clinical note dated 11/06/13 indicated the patient utilizing hydrocodone. The patient was recommended for MR arthrogram of the left wrist. Utilization review dated 02/13/14 resulted in denial for MR arthrogram of the left wrist as no information was submitted regarding reasonable course of conservative care. Additionally no additional progressive focal deficits were identified

indicating the need for MR arthrogram. Utilization review dated 03/13/14 resulted in denial as no information was submitted regarding additional symptoms.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation indicates the patient complaining of left wrist pain despite previous surgical intervention. MR arthrogram would be indicated in the wrist provided that the patient meets specific criteria, including plain films revealing significant findings in the patient completed conservative treatment. Clinical notes mentioned the patient completing a full course of conservative treatment. However, this appears to have been completed in 2012. No additional information was submitted regarding recent completion of any conservative treatment. Additionally no information was submitted regarding plain films confirming normal findings despite chronic wrist pain. As such, it is the opinion of this reviewer that the request for MR arthrogram of the left wrist is not recommended as medically necessary.

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)