



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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**Notice of Independent Review Decision**

**DATE OF REVIEW: 7/14/2014**

**IRO CASE #**

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

Right Wrist MRI.

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

**M.D. Board Certified in Plastic Surgery and General Surgery/ Hand 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Document Type	Date(s) - Month/Day/Year
Department of Insurance Notice of Case Assignment	6/24/2014
injured Employee IRO Request Form	6/23/2014
Utilization Review Determination Reconsideration / Appeal of Adverse Determination	1/30/2014 2/20/2014
Clinical Notes	3/21/2012-1/22/2014
Operative Report	4/25/2012

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a female. She was injured on xx/xx/xx. She had a sudden onset of pain in her right wrist, heard a pop in her wrist, and then the wrist became painful. In notes of August 14, 2012 the history of her treatment is as follows:

- April 2010 occupational therapy and rehabilitation
- April 30, 2010 injection
- May 13, 2010 MRI



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- May 30 brace ordered
- Sept 8, 2010 right wrist injection
- Sept 2011 diagnosed
- March 21, 2012 release of the tendon surgery

In Jan 22, 2014 note: patient continues to have stiffness and numbness just distal to her injection. He is recommending MRI to further evaluate her wrist.

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

Per ODG references, the requested "Right Wrist MRI" is medically necessary. Based on a review of all the records, an MRI is indicated. The operative report is detailed and the surgeon followed all the right steps. The history and course of events point to the presence of additional pathology, and in the face of a normal X-ray, an MRI is indicated.

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

- 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