

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/14/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI with arthrogram, for the right wrist

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

MD, Board Certified Orthopedic Surgeon (Joint)

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who reportedly was injured on xx/xx/xx when she tripped and fell. Per history and physical on 03/11/14, she complains of right wrist pain. Current medications are Celebrex, Triamterene, Carbamazepine, Zyrtec, Pantoprazole, and Gabapentin. X-rays are normal. The patient was placed in a thumb spica cast today. The claimant also is being treated for right shoulder pain, and ultimately underwent right shoulder surgery with rotator cuff repair and acromioplasty on 06/02/14. Short arm cast was removed and examination of the right wrist on 04/01/14 revealed tenderness of the TFCC, no crepitus, negative shuck's test and full active range of motion. The claimant was continued on limited duty. MRI arthrogram of the right wrist was recommended. Per utilization review determination dated 04/09/14 MRI arthrogram was non-certified as medically necessary noting that there is only documentation that the claimant had worn a cast. There was no indication that the claimant had undergone any physical therapy. A reconsideration request was denied on 05/09/14, noting that there was no documentation indicating any acute neurologic or orthopedic impairments or specific functional impairment. Diagnosis was wrist sprain, and wrist was immobilized. Claimant now has full range of motion with some tenderness. There is no evidence of response to physical therapy or home exercise program.

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

Based on the clinical information provided, the request for MRI arthrogram of the right wrist is not recommended as medically necessary. The claimant was injured when she tripped and fell. She complains of right wrist pain. She was diagnosed with right wrist sprain and was placed in thumb spica cast. No other conservative care was documented to include physical

therapy/home exercise program. Examination revealed only some tenderness with full range of motion and no crepitus. No special orthopedic testing was documented. Given the clinical data submitted for review, medical necessity is not established and this reviewer recommends upholding the previous denials on IRO.

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)