

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Mar/11/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** left wrist arthrogram & injection

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

**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 a left wrist arthrogram & injection 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 on it on xx/xx/xx. The clinical note dated 08/12/13 mentions the patient able to demonstrate 142 degrees of left elbow flexion, 55 degrees of wrist flexion, 86 degrees of extension, 16 degrees of radial deviation, and 27 degrees of ulnar deviation. The patient was further able to demonstrate 3+ to 4+/5 strength throughout the left wrist. The patient was recommended for skilled physical therapy at that time. The MRI of the left wrist dated 10/11/13 revealed a thinning of the radial aspect of the TFCC. An increased T2 signal was identified at the median nerve possibly correlating with symptoms associated with carpal tunnel syndrome. Fluid was revealed at the extensor carpi radialis longus and the brevis tendon sheaths. The clinical note dated 11/29/13 mentions the patient utilizing medications as well as topical creams and a wrist brace. X-rays of the left wrist revealed no acute abnormalities. The clinical note dated 01/09/14 indicates the patient undergoing a Kenalog injection at the TFCC and the ulnar gutter.

The utilization review dated 12/23/13 indicates the request for a repeat MR arthrogram resulting in a denial as no significant changes were identified with the patient's clinical presentation. No evidence of significant musculoskeletal or neurologic deficits was noted.

The utilization review dated 01/23/14 resulted in a denial as no failure of the provided objective evidence of progression in the patient's condition was identified. No significant exam findings were submitted supporting the necessity for an arthrogram. No response following the patient's injection was provided in the documentation.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of left wrist pain. Repeat imaging studies would be indicated upon significant changes noted by clinical exam. No information was submitted regarding the patient's functional or neurologic deficits indicating a significant change in the patient's presentation. Furthermore, no information was submitted regarding the patient's response to the previous injection. Given these findings, the request is not indicated. As such, it is the opinion of this reviewer that the request for a left wrist arthrogram & injection 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)