



Notice of Independent Review Decision

**DATE OF REVIEW:** 11/20/07

**AMENDED DATE:** 11/27/07

**IRO CASE #:**

**NAME:**

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

Determine the medical necessity for the previously denied repeat electromyogram/nerve conduction velocity (EMG/NCV) to the right upper extremity (CPT code 95860, 95900, 95903, 95904).

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

Texas Licensed Orthopedic Surgeon

**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)

The previously denied request for repeat EMG/NCV to the right upper extremity (CPT code 95860, 95900, 95903, 95904).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Nurse UM Summary, undated
2. Peer Reviews 10/18/07, 11/07/07
3. EMG / NCS 05/12/03 , 02/22/05
4. MRI right shoulder 05/19/03
5. Operative report 08/22/03
6. Occupational therapy record 12/11/03
7. Dr. OV 08/24/04 , 10./09/07 , 10/23/07
8. MRI right wrist 03/22/05
9. Fax 11/12/07

**NO GUIDELINES WERE PROVIDED BY THE URA FOR REVIEW.**  
**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:**  
**Gender:** Female  
**Date of Injury:** xx/xx/xx  
**Mechanism of Injury:** Not provided for this review.  
**Diagnosis:** Injury to ulnar nerve.

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

This xx year old female claimant reportedly had an injury to her right arm on xx/xx/xx. The records indicated that the claimant initially treated conservatively with benefit until an exacerbation of symptoms was noted in 2003. Symptoms included numbness, tingling and periodic tremors in the hand and pain into the right upper extremity. An EMG/ NCS was performed on 5/12/03, which showed evidence of a mild right carpal tunnel syndrome and mild right cubital tunnel syndrome. The claimant subsequently underwent an excision of a right dorsal wrist ganglion, limited incision carpal tunnel release and submuscular transposition of the ulnar nerve at the elbow on 8/22/03. Right arm pain continued in 2004, and an EMG/ NCS was repeated on 2/22/05, which showed a mild recurrence of carpal tunnel syndrome. An MRI of the right wrist was also done in 2005, which showed a small amount of fluid present in the tendon sheath of the extensor compartment. A physician examination, dated 10/9/07, noted the claimant with a reoccurrence of arm pain. There was a positive Tinel's sign along the ulnar nerve on examination, and some diminished sensation in the ulnar distribution of the hand. The physician diagnosed exacerbation of an old injury. A repeat EMG/NCS was requested. On a 10/23/07 follow-up visit, continued conservative modalities were recommended, along with the nerve test. This claimant had already undergone ulnar nerve transposition. As such, the treatment for ulnar nerve compression has already been completed. The findings on physical examinations of October 9 and October 23 are non-specific. This claimant may be expected to have some mildly diminished ulnar sensation indefinitely. Based on clinical review, and based on the guideline, this reviewer would agree with the prior determinations in this case. The information submitted simply does not support the request for repeated electro-diagnostics at this time.

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

- ACOEM- AMERICAN 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**
  - Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Carpal Tunnel Syndrome: Electro-diagnostic studies
- 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)**