



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non- network (WC)

Original decision date: 04/10/2008

Amendment date: 04/16/2008

DATE OF REVIEW: 04/10/2008 AMENDMENT DATE: 04/16/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat EMG/NCV RUE (95860; 95900; 95903; 95904)

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

Texas State Licensed MD Board Certified Orthopaedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY:

This individual was involved in an accident on xx/xx/xx. The patient has subsequently had complaint referable to the right upper extremity.

She has had a clicking in her elbow as well as a pain in the elbow with numbness and tingling to the thumb and index finger. She was treated with physical therapy. She subsequently has been referred to a specialist. I should note that EMGs were carried out on August 23, 2007. These studies did not show any evidence of a carpal tunnel syndrome. It did show an ulnar nerve slowing. The patient had now been recommended to have another EMG.

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

In my opinion, the procedure is unnecessary and unwarranted. The patient has had an EMG some six months previously. It is unlikely that this additional EMG would provide usual clinical



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information.

I have based this opinion on medical judgment, clinical experience, and expertise in accordance with accepted medical standards. I have also based this opinion on Official Disability Guidelines and Treatment Guidelines; I would uphold the previous reviewer's finding of an adverse determination.

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
- 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)