

I-Decisions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

(207) 338-1141 (phone)

(866) 676-7547 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient EMG to left upper extremity (LUE)

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

MD, Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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.

The reviewer finds that medical necessity does not exist for Outpatient EMG to left upper extremity (LUE).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/8/08, 8/20/08

ODG Guidelines and Treatment Guidelines

Dr. clinic notes 3/27/08, 4/3/08, 4/10/08, 4/17/08, 4/22/08, 5/5/08, 5/30/08, 6/2/08, 6/9/08, 6/16/08, 6/20/08, 6/24/08, 7/3/08, 5/13/08, 5/21/08, 5/27/08, 6/4/08

X-Rays reports 03/25/2008, 3/27/08, 4/3/08, 4/10/08, 4/22/08, 5/5/08, 5/27/08, 7/3/08

PT Notes, 05/13/2008, 05/21/2008, 05/30/2008, 06/02/2008, 06/04/2008, 06/09/2008, 06/16/200, 06/20/2008, 06/24/2008

Accident Report, xx/xx/xx

SORM, 5/15/08
Emergency Physician Records, xx/xx/xx
Physical Capacity Report, 5/27/08, 7/3/08
Occupational Therapy Evaluation, 6/3/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female with a date of injury xx/xx/xx who tripped and fell and landed on her hands and knees. She sustained a distal fracture of her radius on the left. She also had a fracture of the right radial head at the elbow and bilateral knee contusions. She complains of discomfort and weakness of the left hand and wrist. X-rays reveals early healing of the fracture. She has worn splints on the left wrist. Her neurological examination reveals poor pinch and grip of her left hand. The Tinel's sign is positive at the wrist. There is decrease in the thenar eminence of the left hand. The provider is recommending an EMG to the left upper extremity.

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

The left upper extremity EMG is not medically necessary. The claimant has some evidence of carpal tunnel syndrome given the positive Tinel's sign at the wrist and decrease in the thenar eminence of the hand. However, an EMG looks for a radiculopathy. The claimant has no evidence of a radiculopathy. EMG is not recommended as necessary in the ODG criteria. The reviewer finds that medical necessity does not exist for Outpatient EMG to left upper extremity (LUE).

2008 *Official Disability Guidelines*, 13th edition

"Carpal Tunnel" chapter

"Electrodiagnostic studies: Recommended in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary."

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 KNOWLEDGBASE
- 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)