



MedHealth Review, Inc.  
445 E. FM 1382  
Suite 3344  
Cedar Hill, TX 75104  
Ph 972-775-1411  
Fax 972-775-8035

**DATE OF REVIEW:** 5/11/09

**IRO CASE #:**

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

The services under dispute include CPT codes 95900 motor nerve conduction (2 units), 95903 motor nerve conduction (4 units), 95904 sensory nerve conduction (6 units) and 95961 electrode stimulation (1 unit).

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

The reviewer is a Medical Doctor who is a board certified Neurologist. This reviewer has been practicing for greater than 10 years in this field and performs this type of procedure in daily practice.

**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 reviewer agrees with the previous adverse determination regarding all procedures under review.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Diagnostics, the patient and Intracorp.

These records consist of the following (duplicate records are only listed from one source): 7/21/08 exam report by, DO, 5/12/08 to 6/16/08 reports by, MD, 10/18/07 report , 2/26/08 to 5/1/08 reports , 10/18/07 report by LPC, interdisciplinary conference sheets, treatment plans from July of 2008,

interdisciplinary rehab program reports from 6/9/08 to 7/21/08, psychology progress notes 6/9/08 to 7/21/08, group therapy notes from 6/9/08 to 7/21/08 and daily progress notes from 6/9/08 to 7/21/08.

Patient: letter of clarification from 1/16/09, 6/18/07 operative report, 9/25/07 exam report, 12/6/06, 2/1/07 and 9/19/07 PPE reports, 2/16/07 to 8/29/07 reports by MD, various DWC 73's, 8/6/07 report by, DC, 12/5/06 and 1/10/07 CMT reports, 1/6/09 clarification letter, 12/12/08 letter by, DC, 1/22/09 letter of clarification and 2/9/09 DD report

Carrier: 4/24/09 letter by, 4/1/09 denial report by, DC, 3/27/09 precert request, 3/24/09 precert request, 4/1/09 denial letter, 4/10/09 denial report by, MD, 4/7/09 precert appeal, 3/30/09 report by MD, 3/24/09 re-eval , 3/26/09 patient face sheet and 4/10/09 denial letter.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient is a female. She reported an injury on xx-xx-xx. Her complaint was pain in the right wrist and hand after repetitive tightening of screws with a hand operated screwdriver. She had an endoscopic carpal tunnel release on the right hand on 11/29/05 and then later an open carpal tunnel release on 6/18/07. She then developed a right ring trigger finger that was first documented on 7/21/08. A DD exam was performed by Dr. on 2/9/09 at which point she was placed at MMI on 12/3/07 with 0% impairment.

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

The reviewer indicates that the patient's designated doctor evaluation did not indicate any findings of objective sensory or motor deficit in the right upper extremity. The ODG indicates "Recommended in patients with clinical signs of CTS 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. In general, carpal tunnel syndrome should be proven by positive findings on clinical examination and should be supported by nerve conduction tests before surgery is undertaken."

The DD placed her at MMI without finding objective symptoms and the ODG recommends this type of procedure when a surgical procedure is indicated. The records do not indicate that a further surgical procedure is in the works; therefore, based upon the ODG this EMG/NCV is not medically necessary 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
- 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)