

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCS to left upper extremity (95860)

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

M.D., Board certified in Orthopedic 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

, 5/25/10, 6/11/10

Surgery Group 5/7/10 to 6/29/10

Solutions 5/21/10, 6/9/10

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker whose injury dates back to xx/xx/xx. She complains of nonspecific subjective numbness and pain about the wrist. She has had a physical examination that documented tenderness about the wrist, some synovial swelling, and a diagnosis that has been attributed to synovitis, tenosynovitis, and wrist sprain.

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

The recommendation for these studies is not substantiated by the physical examination. There is neither Tinel's sign or Phalen's sign, documentation of objective numbness, two-point discrimination, or any other signs of carpal tunnel syndrome. There is, furthermore, no evidence based on physical examination of numbness affecting the ulnar distribution to lead the treating physician to a complementary diagnosis by EMG of ulnar neuropathy. Even if the EMG/nerve conduction study on this individual was positive, given the total absence of objective physical findings and very murky subjective/objective symptoms, this patient would not meet the criteria as per the Official Disability Guidelines and Treatment Guidelines. It is because of the significant absence of physical findings and corresponding patient symptoms documented within the record and the failure to explain why the Official Disability Guidelines and Treatment Guidelines should be set aside in this individual's case, that this reviewer cannot overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for EMG/NCS to left upper extremity (95860).

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)