

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/03/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** EMG/NCV UE 95860 95903

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Electrodiagnostic Medicine

**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**

Adverse Determination Letters, 11/3/09, 11/17/09  
MHHS Radiology Reports 2/16/09  
Pain Relief Center 5/27/09, 6/23/09, 7/21/09, 10/27/09, 11/24/09  
Diagnostic Imaging 3/17/09  
M.D. 6/8/09, 7/9/09, 10/28/09  
MRI and Diagnostic 5/18/09  
Surgery Specialty Hospitals 7/14/09  
ODG-TWC

**PATIENT CLINICAL HISTORY SUMMARY**

This patient is a male who was injured on xx/xx/xx. He had a Lisfranc fracture for which he underwent an ORIF. He had a rotator cuff injury and repair in xxxx/xx/xx. Dr. noted right wrist pain in his May 2009 evaluation and had an MRI done. This showed a bone bruise, but no description of nerve injury. Dr. did not describe neurological problems in the right hand. Dr. reported that this man had pain in his upper extremity. The examinations did not describe any sensory deficits, with normal reflexes and strength.

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

Dr. noted some upper extremity pain, but never described where and in what distribution. It was unclear from the records if the provider was considering a radiculopathy or nerve compression. There was no sensory nerve description. The motor description was superficial and normal. Electrodiagnostic studies can be justified if there is a suggestion of CTS, but none was described in the records reviewed. The same with nerve injury after forearm fractures, and none were described. There was nothing provided to suggest a thoracic outlet

syndrome or cervical radiculopathy. In the absence of this information, the reviewer cannot disagree with the prior adverse determinations in this case. The reviewer finds that medical necessity does not exist at this time for EMG/NCV UE 95860 95903.

**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)