



**REVIEWER’S REPORT**

**IRO CASE #:**

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

Cortisone injections and bilateral upper extremity EMG/nerve conduction studies

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients who have suffered traumatic injuries

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Clinical notes, 12/11/09, 12/28/09, 01/25/10, 02/22/10, 03/11/10, 03/25/10, 04/22/10, and 05/18/10
2. Activity restrictions, 02/22/10
3. Operative report, 03/11/10 for radial tunnel release and functional lengthening of the extensor carpi radialis brevis and intramuscular septum as well as extensor digitorum communis
4. Fax cover sheets
5. Request for medical records, 06/09/10

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured employee suffered an injury while attempting to place a part on a machine on xx/xx/xx. The injured employee had complaints of right elbow pain and left wrist pain. He underwent right radial tunnel release and extensor carpi radialis brevis lengthening as well as surgical procedure on 03/11/10. He has had persistent right upper extremity elbow tenderness and diffuse left wrist tenderness. The request is now for Celestone injections, location of the injections not clear, and upper extremity EMG/nerve conduction studies to be performed bilaterally. There is mention that a Designated Doctor Evaluation included recommendations similar to those which have been requested for approval at this time; however, there is no documentation of the Designated Doctor Evaluation.

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

At the present time there are no physical findings which would indicate that a compressive neuropathy is present. The specific location for cortisone injections is not documented. It would appear that prior denials of this request to perform Celestone injections and to obtain bilateral upper extremity EMG/nerve conduction studies were appropriate and should be upheld.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)