



## Notice of Independent Review Decision

**DATE OF REVIEW:** 02/25/10

**IRO CASE #:**

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

EMG/NCS of the Upper Right Extremity

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

Board Certified in Physical Medicine and Rehabilitation

### **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.

EMG/NCS of the Upper Right Extremity – OVERTURNED

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Evaluation, M.D. , 08/24/09

- Correspondence, Dr., 08/26/09
- Progress Note, Dr., 09/14/09, 10/19/09, 11/30/09
- Initial Therapy Evaluation, OTR, 09/14/09
- Daily Treatment Note, Ms., 09/22/09, 10/19/09, 11/02/09, 11/09/09, 11/30/09
- Denial Letter, 12/11/09, 01/12/10
- Correspondence, 02/02/10

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained a hyperextension type injury when his thumb impacted against a xxxx. He was fitted into a plastic of paris thumb splint. He underwent physical therapy. After therapy, he reported having some symptoms of numbness into his palm including the thumb, index, long and ring fingers. Dr. felt that the patient appeared to have some low grade carpal tunnel syndrome.

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

It is my medical opinion that the EMG/nerve conduction study of the right upper extremity proposed by the treating physician is indeed reasonable and medically necessary,

Dr., the hand surgeon, has been caring for the patient for the avulsion of the collateral ligament. He has proposed an EMG be performed because of persistent numbness of the hand and fingers, which has developed along with assisted weakness as a result of extensive splinting required for treatment of the thumb fracture. The onset of the numbness has been well documented as well as the rationale for requiring electrodiagnostic testing. As the patient is required to use his hand during the course of his employment, it is entirely reasonable and necessary to evaluate this numbness and ensure that there is no iatrogenic nerve injury that has occurred as a result of treatment for the avulsion fracture of the thumb.

Utilization of electrodiagnostic testing to properly evaluate the nerve function is within the context of the ODG. While no specific diagnostic physical tests are noted which lead to carpal tunnel syndrome, their relevance in the diagnosis of carpal tunnel syndrome is minimal, and their sensitivity and specificity are quite poor. I, therefore, feel that the nerve conduction study is reasonable and appropriate to evaluate this patient.

**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)**