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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient EMG NCV of bilateral upper extremities (BUE)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Pain 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that medical necessity is not established for the requested outpatient EMG NCV of bilateral upper extremities (BUE)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Notice of utilization review findings 01/04/13

Notice of utilization review findings 01/17/13

Pre-authorization request 01/02/12

Patient information form 12/18/12

Office notes 03/15/11-03/11/13

Pre-authorization appeal request/fax cover 01/11/13

Authorization to disclose information to the Social Security Administration 09/25/12

Manual muscle test and range of motion exam 01/16/12

EMG/NCV 11/21/02

EMG/NCV 11/07/02

EMG/NCV 11/04/09

MRI right elbow 09/14/01

MRI left wrist 09/13/01

MRI right wrist 09/13/01

MRI left elbow 09/13/01

Letter of medical necessity for left wrist joint block steroid injection 02/13/12

Medical records/peer review 02/10/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a female whose date of injury was xxxxxx. Records indicated that the claimant developed bilateral wrist and elbow issues secondary to repetitive use/computer use. After failing a course of conservative treatment including splinting and anti-inflammatory medications, the claimant underwent multiple surgical procedures including bilateral carpal tunnel release in 03/00; right ulnar nerve transposition 06/00; right open carpal tunnel release redo and right ulnar nerve redo

decompression 02/01. Repeat EMG/NCS on 11/21/02 revealed subtle evidence of right radio sensory graft compression at the level of the right wrist. A right radio sensory nerve lesion was indicated by reduced radial SNAP amplitude values recorded at the right first digit relative to the contralateral study. Needle EMG exam was consistent with the previous ulnar nerve compression at the level of the left elbow. Active ulnar nerve compression was not demonstrated.

Records indicated that the claimant subsequently participated in an outpatient chronic pain management program in 2008. Subsequent electro-diagnostic testing on 11/04/09 showed chronic neurogenic changes at the bilateral lower cervical paraspinal muscles and the muscles enervated by bilateral C7-8 nerve root, right more than left, consistent with bilateral lower cervical mild chronic radiculopathy with mild chronic neurogenic changes without acute process or active denervation; there was no evidence suggestive of peripheral neuropathy, myopathy, or nerve entrapment. The claimant underwent right wrist joint block on 03/19/10, which the claimant stated helped decrease her pain.

A request for outpatient EMG/NCV of the bilateral upper extremities was non-authorized per review dated 01/04/13. It was noted that office visit from 12/17/12 showed the claimant with sensory on the right at 80% and 90%. Motor was 4/5. Valium 10mg was prescribed. The note was mostly illegible. Office visit note of 11/19/12 showed the claimant with intense burning and searing pain of the right top part of the right hand. The reviewer determined the request did not meet Official Disability Guidelines criteria in that the clinical provided did not establish possibility of a peripheral nerve entrapment or neuropathy and therefore the request was not authorized.

A reconsideration request for outpatient EMG/NCV of the bilateral upper extremities (BUE) was reviewed on 01/17/13 and the original decision was upheld, recommending non-authorization of the request. It was noted that the claimant was reported to have bilateral carpal tunnel syndrome. She had intracarpal decompression on 03/21/11 on the right and left ulnar decompression on 02/13/01. She now has pain in the root of the right thumb and the top of the right hand. Apparently, she has burning and tingling in the fingers and also reports pain at the left side of the right wrist at a Dequervain's surgery site. The reviewer noted that Dequervain's is very different than carpal tunnel syndrome as this is a thumb pathology. There is no indication that the claimant underwent a procedure in this region as related to a work injury. There is inadequate information provided to allow for this procedure, including lack of a complete history and physical and the request is denied per the previous reviewer.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The records submitted for review indicate that the claimant was injured on xx/xx/xx and complained of bilateral wrist and elbow issues. After failing conservative care, the claimant underwent bilateral carpal tunnel releases in 2000 with right ulnar nerve transposition in 2000 and re-do open carpal tunnel release on the right as well as right ulnar nerve re-do decompression in 2001. The claimant continued to complain of right wrist/hand pain. Clinical evaluation on 12/17/12 reported 80% sensory right hand and 90% sensory left hand; 4/5 motor bilaterally; +1 reflexes bilaterally upper extremities. There were no findings on examination such as positive Tinel's, positive Phalen's, positive Finkelstein's, or other indications of a peripheral nerve entrapment or neuropathy. Based on the clinical data provider, it is the opinion of this reviewer that medical necessity is not established for the requested outpatient EMG NCV of bilateral upper extremities (BUE).

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)