

Applied Resolutions LLC
An Independent Review Organization

Phone Number:
(817) 405-3524

900 N Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Email: appliedresolutions@irosolutions.com

Fax Number:
(817) 385-9609

Notice of Independent Review Decision

Case Number

Date of Notice: 02/15/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine and Rehabilitation

Description of the service or services in dispute:

NCV Lower extremities

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)

Patient Clinical History (Summary)

The patient is a male. On XX/XX/XX, he was seen in the emergency department. He described a motor vehicle accident in which he sustained right elbow fracture dislocation. He was taken to surgery for external fixator device. On XX/XX/XX, electrodiagnostic studies revealed bilateral median entrapment neuropathy at the wrist indicative of carpal tunnel syndrome right greater than left with concordant bilateral mild ulnar neuropathy. On XX/XX/XX, the patient was seen in clinic. He continued to report vertigo and stated he had cognitive disorders. It was noted, nerve conduction study revealed evidence of mild carpal tunnel syndrome bilaterally. On exam, he had hyperesthesia in the right medial nerve distribution, and vibration sense was decreased in the left foot. A nerve conduction study was recommended to evaluate for polyneuropathy versus lumbar radiculopathy.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On XX/XX/XX, a utilization review report indicated that the examination did not provide evidence of decreased sensation or strength in the thigh. Furthermore, it was noted the patient denied back pain. It was noted the patient had not received conservative therapy in regards to his right leg and therefore, the request was non-certified. On XX/XX/XX, a reconsideration determination stated that the previous determination was upheld, as there had been no additional information submitted for review that would overturn the previous review.

The guidelines state there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy.

It is the opinion of this reviewer that the request for NCV lower extremities is not medically necessary and prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- 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 and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

