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DATE OF REVIEW: AUGUST 1, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCV upper extremities and CT/myelogram of cervical spine

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

The physician providing this review is a physician, doctor of medicine. The reviewer is national board certified in physical medicine and rehabilitation. The reviewer is a member of American Academy of Physical Medicine and Rehabilitation. The reviewer has been in active practice for twenty-three years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Care

DDE (02/21/07)

M.D., spine surgeon

Office notes (05/01/07 - 06/30/07)

Diagnostics (xx/xx/xx – 12/01/06)

Utilization reviews (06/15/07 & 06/22/07)

DDE/RME (02/21/07 – 07/05/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was pulling books off the printer and stacking them when she felt pain in her neck and left shoulder.

In xx/xx/xx, magnetic resonance imaging (MRI) of the cervical spine revealed: 1-2 mm posterior central disc protrusion at C3-C4; 2-mm posterior central disc protrusion at C4-C5; 2-3 mm suspected left paracentral posterior disc protrusion at C5-C6; low-lying and pointed cerebellar tonsils compatible with Chiari malformation type I; and reversal of the normal lordotic curvature.

MRI of the left shoulder revealed: (1) Rotator cuff tendonitis. (2) Small effusion. (3) Mild acromioclavicular (AC) joint hypertrophic arthropathy. Mild bone marrow edema/contusion of the distal clavicle. Trace fluid within the AC joint compatible

with synovitis versus sequelae to previous trauma. (4) Mild biceps tenosynovitis. Electromyography/nerve conduction velocity (EMG/NCV) studies of the upper extremities including cervical paraspinals were normal. According to the evaluator, the weakness and numbness in the entire left upper extremity was unexplained, and was mostly likely a psychosomatic presentation. A central lesion in the brain could also not be excluded.

In February 2007, M.D., a designated doctor, evaluated the patient. He noted the patient had complaints of pain in neck and left shoulder, numbness and tingling in the left fingers, and weakness of the left arm. Past treatment had consisted of three to four months of physical therapy (PT), transcutaneous electrical nerve stimulation (TENS) unit, ultrasound, and one injection to the neck and shoulder. Medications included naproxen and tramadol. Examination showed tenderness from C4 through C7 on the left, positive foraminal compression test, positive Neer impingement on the left, and positive anterior apprehension test on the left. Dr. opined that the patient was not at maximum medical improvement (MMI) as she had been scheduled for injections to the left shoulder and cervical spine. He added that the patient might need a pain program.

M.D., a spine surgeon, diagnosed cervical radiculopathy and disc herniation at C5-C6 on the left and recommended further diagnostics in the form of computerized tomography (CT) myelogram of the cervical spine and upper extremity EMG/NCV studies.

In a required medical evaluation (RME), M.D., opined: The patient did not have evidence of a serious or significant shoulder or neck injury. She did not require anterior cervical discectomy or fusion. After reviewing the surveillance video, it was clear that the patient's behavior pattern in terms of use of her left shoulder was different when she was not in the presence of a physician. In the presence of a physician, she would not move her shoulder at all whereas she was clearly able to move her left shoulder in a nonpainful manner on the video. She did not have a surgical problem either of the neck or shoulder.

On June 15, 2007, M.D., denied the request for EMG/NCV and CT myelogram of the cervical spine. Rationale: *The clinician has not demonstrated progressive neurologic changes which would lead to repeating the EMG. Additionally, the MRI in November 2006, showed no neural impingement. Additional discussion was needed regarding the clinical indication to pursue these repeat and additional studies.*

On June 22, 2007, M.D., denied the appeal for EMG/NCV and CT myelogram of the cervical spine. Rationale: *The EMG/NCV findings might not be predictive of surgical outcome in cervical surgery and patients might still benefit from surgery even in the absence of EMG/NCV findings of nerve root impingement. The myelography was not recommended except for surgical planning.*

On July 5, 2007, M.D., performed a designated doctor evaluation (DDE) and diagnosed cervical herniated disc disease with radiculopathy at the level of C5-C6 and tendinitis of the shoulder, and possibly carpal tunnel syndrome (CTS) bilaterally. Dr. opined that the patient was not at MMI as she was still receiving

active therapy and was scheduled for surgery to the left shoulder and wrist on July 9, 2007. It was his opinion that the patient would not be able to return to work currently.

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

PATIENT HAD AN EMG IN LATE 2006 AND WAS REPORTED AS NORMAL. THERE ARE MULTIPLE EXAMINATIONS REVEALING NO EVIDENCE OF A RADICULOPATHY AND AT THE VERY LEAST NO DETERIORATION. MRI WAS ESSENTIALLY NEGATIVE AND THERE DOES NOT APPEAR TO BE A SURGICAL LESION. IN CONCLUSION, THERE IS NO INDICATION TO SUPPORT THE REQUEST FOR THESE ADDITIONAL TESTS.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**