

Notice of Independent Review Decision

DATE OF REVIEW: 11/01/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV of left upper extremity and EMG/CCV right upper extremity

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

The TMF physician reviewer is a board certified plastic surgeon, is on the TDI-WC approved doctor's list and is familiar with the treatment or proposed treatment.

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.

It is determined that the EMG/NCV of left upper extremity and EMG/CCV of the right upper extremity are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice to Utilization Review Agent of Assignment of IRO – 10/15/07
- Patient referral for OT – 01/22/07, 04/20/07
- Patient referral for PT – 03/21/07
- Occupational Therapy Prescription – 01/11/07, 04/11/07
- Occupational Therapy notes – 01/10/07 to 01/18/07

- Preauthorization request for PT – 02/05/07, 03/21/07, 04/20/07
- Physical therapy request – 01/30/07, 03/27/07
- Office visit notes by Dr. – 01/30/07 to 03/27/07
- Physical Therapy notes – 09/27/06 to 03/21/07
- Preauthorization request for Left carpal tunnel release – 02/06/07
- Office visit notes by Dr. – 10/04/06 to 09/21/07
- Office visit notes by Dr. – 08/29/06 to 09/05/06
- Consultation note by Dr. – 09/20/06
- Report of EMG by Dr. – 09/01/06 to 11/07/06
- Prescription for repeat bilateral EMG/NCV – 08/17/07
- Progress notes by Dr. – 05/02/07 to 08/18/07
- Letter of Determination – 09/14/07, 10/02/07
- **Note:** did provide ODG Guidelines for NCS/EMG studies

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx while working long hours on the computer resulting in pain to her wrists and hands radiating to her arms, shoulders, and neck. She was diagnosed with bilateral upper extremity neuropathy. The patient has been treated with occupational and physical therapy, injections and surgery in the form of a carpal tunnel release on the right on 01/28/07 and on the left on 03/22/07.

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

This patient underwent an EMG/NCS in September of 2006.

Electromyography: The American association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was sensitive (50-70%) and specific (65-85%). A positive diagnosis of radiculopathy requires the identification of neurological abnormalities in 2 or more muscles that share the same root innervation but differ in peripheral blood supply.

Timing: Timing is important as nerve roots compression will reflect a positive as active changes are occurring. Changes in denervation develop within the first to third week after compression and re-innervation is found in 3-6 months.

Acute findings: Identification of fibrillation potentials in denervated muscles with normal motor unit action potentials.

Indications: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology.

Therefore, it is determined that the medical record lacks documentation to indicate any substantial change in the injured worker's condition and support the necessity for a repeat EMG/NCS.

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)

The American Association of Electrodiagnostic Medicine