INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 04/12/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:
EMG/NCV, right upper extremity, and MRI scan of cervical spine without contrast.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.O., duly licensed in State of Texas, Fellowship Trained in Pain Medicine, ABA, Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine, with over twenty years of clinical experience in active practice in the specialty of Pain Management

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be:

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
723.4	***95860***		***Prosp***						***Upheld***
723.4	***95900***		***Prosp***						***Upheld***
723.4	***95904***		***Prosp.***						***Upheld***
723.4	***95903***		***Prosp***						***Upheld***

INFORMATION PROVIDED FOR REVIEW:
1. TDI case assignment
2. MRI scan of the cervical spine without contrast dated 06/02/06
3. Orthopedic evaluations and follow up 01/08/08 and 01/13/08
4. Required Medical Examination, 03/04/08
5. Letters of denial with respective criteria, 03/14/08 and 03/24/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This claimant was injured. No specific information was provided regarding the mechanism of her work injury. She apparently underwent left knee arthroscopic surgery on 10/11/06. On 06/02/06 a cervical MRI scan was performed to evaluate complaint of neck pain radiating to the upper extremities, worse on the right. The MRI scan demonstrated evidence of a moderate right C4/C5 disc protrusion with spinal cord impingement as well as a right posterolateral and paracentral disc protrusion at C5/C6 also impinging on the cord. Both levels also showed mild relative central canal stenosis.

On 06/19/07 the claimant was evaluated and an EMG/NCV studies were performed for evaluation of her neck pain radiating to the right upper extremity. Physical examination documented left more than right cervical pain with range of motion. Nerve conduction and EMG studies were both entirely normal, demonstrating "no evidence of a right upper extremity neuropathic process."
On 01/08/08 the claimant was evaluated for complaint in her left knee.
On 02/13/08 she was evaluated for neck and bilateral upper extremity pain, as well as left lower extremity, left knee, and thoracic pain. No mention was documented of the previous MRI scan findings. It was noted that the claimant had had studies only for the lower extremity and right wrist and only x-rays on the cervical spine showing "unremarkable findings." MRI scan of the cervical spine, EMG study of both upper extremities, and admission to a chronic pain management program were recommended.

A Designated Doctor Evaluation was performed on 03/04/08. In that evaluation the claimant's complaints of low back, neck, shoulder, and right upper extremity pain were noted. Physical examination documented decreased cervical range of motion in all planes with normal muscle strength, normal reflexes, and no dermatomal abnormality in sensation between the left and right upper extremities. It was stated that the claimant was at maximum medical improvement as of 07/27/07, awarding a 4% whole person impairment.

The request for EMG/NCV studies as well as cervical MRI scan was then evaluated by two separate physician advisers independently, both of whom recommended nonauthorization of the request based on ODG Guidelines and ACOEM Guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
Despite this claimant's subjective complaints of cervical and right upper extremity pain, independent physical examination fails to document any valid signs of cervical radiculopathy. Moreover, this claimant has already had cervical MRI scan and right upper extremity EMG studies performed on 06/02/06 and 06/19/07 respectively. There has been no interval change in her subjective pain complaints since those studies were done.

There has, however, been a Designated Doctor Evaluation performed in the interval since these studies were performed with the physical examination documented by the designated doctor demonstrating no evidence of radiculopathy. Therefore, there is no medical reason or necessity for this claimant to undergo another cervical MRI scan or another right upper extremity EMG/NCV study. The EMG/NCV study clearly demonstrated no neurologic abnormalities when it was performed, and the MRI scan demonstrated right C4/C5 and C5/C6 disc bulges, which is sufficient evidence of spine pathology to correlate with the claimant's subjective right upper extremity complaints.

Absent any significant change in her clinical condition since those studies were performed, as well as absent any current physical examination evidence of cervical radiculopathy per the Designated Doctor Evaluation one month ago, there is no support for repeating either of these studies in either ODG Guidelines or ACOEM Treatment Guidelines. The recommendation for non-authorization of these requested procedures is, therefore, upheld.

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

___X__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 judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X___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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)