

# US Decisions, Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW: DECEMBER 7, 2008**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

EMG/NCV Upper Extremities

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

MD, Board Certified Orthopedic Surgeon

### **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.

The reviewer finds that medical necessity does not exist for EMG/NCV Upper Extremities.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 10/3/08, 11/6/08

ODG Guidelines and Treatment Guidelines

DDE, Dr., 12/18/07

MRI lumbar, 03/11/08

Office notes, Dr., 07/29/08, 09/16/08

EMG/NCS, 09/05/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx year old male claimant with a reported slip and fall injury on xx/xx/xx which resulted in right wrist pain and low back pain. The records indicate that the low back pain persisted with associated lower extremity weakness. An EMG/NCS of the bilateral lower extremities done on 09/05/08 showed that the possibility existed for an axonal neuropathy. According to the treating physician, the lower extremity weakness persisted with decreased sensation in both lower extremities. An upper extremity EMG/NCV was requested to compare and possibly identify if the claimant has some axonal problems.

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

The clinical records do not support the suspicion of axial ulnar neuropathy and as such there would be no indication that an EMG would be medically necessary in this particular setting. The patient does not meet criteria specified in the ODG. The reviewer finds that medical necessity does not exist for EMG/NCV Upper Extremities.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates,

Neck and upper back: Electromyography (EMG)

Recommended (needle, not surface) as an option in selected cases.

Indications when particularly helpful: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology such as neuropathy secondary to diabetes or thyroid disease, or evidence of peripheral compression such as carpal tunnel syndrome.

Carpal tunnel syndrome: Electromyography (EMG)

Recommended only in cases where diagnosis is difficult with nerve conduction studies (NCS).

In more difficult cases, needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies (NCS). There are situations in which both electromyography and nerve conduction studies need to be accomplished, such as when defining whether neuropathy is of demyelinating or axonal type. Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies.

**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)