

# Applied Resolutions LLC

*An Independent Review Organization*  
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## Notice of Independent Review Decision

**DATE OF REVIEW:** March 17, 2008

**IRO CASE #:**

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

Right upper extremity EMG/NCS

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

M.D., 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)

Upon independent review the reviewer finds that the requested right upper extremity EMG/NCS is not medically necessary.

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

MRI lumbar spine, 10/27/05  
Placement of SCS, 03/28/06  
Office note, Dr. 12/12/06, 01/04/07, 03/22/07, 01/12/08  
Office note, PA-C, 07/30/07  
Adverse Determination Letters, 01/28/08, 02/05/08  
ODG Guidelines and Treatment Guidelines

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female injured in an unknown manner. She had apparently had low back pain in the past as there was a lumbar MRI performed on 10/27/05 that showed that an L5-S1 laminectomy had been performed. She was seen on 12/12/06 by Dr. for neck and upper back pain. On examination there was hypoesthesia in the C6 dermatome. This persisted on visits on 01/04/07 and 03/22/07. The claimant returned on 01/12/08 to Dr. for pain in her neck and left arm to the hand. On examination there was hypoesthesia in the left C6 distribution with no motor deficits or hyper-reflexia. There was tenderness and spasm as well as a positive left Spurling. A previous cervical MRI in 2004 reportedly showed some C4-5 and 5-6 stenosis on the left. Dr. again requested an EMG. This has been denied and a dispute resolution was requested.

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

Right upper extremity EMG nerve conduction study does not appear to be reasonable and necessary.

This is a female who was injured in an unknown manner with lower back pain and essentially an L5-S1 laminectomy. She was then seen on 12/12/06 for neck and upper back pain with hypoesthesia on the C6 intra dermatome, noted on sequential visits, but with normal motor strength and normal reflexes. There is noted tenderness, and a positive Spurling's sign. A previous cervical spine MRI on 2004 was reported to show C4-5 C5-6 stenosis on the left. The EMG nerve conduction study is not necessary. Notably, present care conservatively has included chiropractic care, and skeletal muscle relaxants, which certainly are reasonable and appropriate. It is not clear how much information the EMG would add to the plan of treatment.

Official Disability Guidelines Treatment in Worker's Comp 2008, Neck and Upper Back Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). ([AAEM, 1999](#)) EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. This is in stark contrast to the lumbar spine where EMG findings have been shown to be highly correlative with symptoms.

*Positive diagnosis of radiculopathy:* Requires the identification of neurogenic abnormalities in two or more muscles that share the same nerve root innervation but differ in their peripheral nerve supply.

## **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)**