

MATUTECH, INC.

PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: September 4, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Electromyography/nerve conduction velocity (EMG/NCV) test of upper extremities

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

Overtuned (Disagree)

Medical documentation **supports** the medical necessity of the electromyography/nerve conduction velocity (EMG/NCV) test of upper extremities

ODG utilized for denials.

PATIENT CLINICAL HISTORY

[SUMMARY]:

The patient is a xx-year-old female who reported an injury on xx/xx/xx. She had numbness and tingling in her right hand due to repetitive movements of her hands at work.

Pre-Injury Records: On xx/xx/xx, the patient fell and sustained injuries to her skull, neck, left wrist, hand, thumb, and lip. In the emergency room (ER), x-rays and computerized tomography (CT) of the cervical spine revealed degenerative changes. She was treated with pain medications. Later, she came under care of , M.D., who treated her with medications and physical therapy (PT). Magnetic resonance imaging (MRI) revealed a small C6-C7 posterior disc herniation, kyphosis, multilevel neuroforaminal stenosis due to uncovertebral joint hypertrophy, and multilevel osteophytic compression fractures. A neurologist saw her for neck pain with radiation to left arm and diagnosed left C7

radiculopathy. Electromyography/nerve conduction velocity (EMG/NCV) study revealed prolonged somatosensory latency of the left median nerve from hand to Erb's point, possibly left brachial plexus problem; and prolonged distal sensory latency on the right median nerve supportive for entrapment or injury of the nerve at the wrist. The patient underwent a cervical epidural steroid injection (ESI) as well as trigger point injections (TPIs) in the left shoulder and cervical regions. In September, she visited an ER for worsening neck pain radiating to the left arm with weakness and inability to turn her head to the left or right. She responded to medications and PT. However, she continued to suffer from left hand numbness and weakness and was referred back to the neurologist for NCV study.

Post-Injury Records: In xx/xx, , M.D., a neurologist, noted decreased pinprick sensation over the left C6-C7 dermatome, decreased vibration distally, and reproduction of symptoms on palpation of left ulnar nerve at the elbow. He recommended MRI of the left elbow to rule out ulnar nerve entrapment. In May 2003, , M.D., a designated doctor, did not place the patient at maximum medical improvement (MMI) for the xx/xx/xx, injury. , M.D., a neurosurgeon, noted complaints of bilateral pain and numbness typically in a carpal tunnel distribution. He had difficulty deciding the exact nature of problems and felt the patient had symptoms of carpal tunnel syndrome (CTS) and possibly of cervical radiculopathy.

, M.D., evaluated the patient for numbness and tingling in her right hand as well as pain in the right forearm and shoulder and neck. The patient was undergoing conservative treatment and despite her treatment with anti-inflammatory and splint, she had ongoing problems. Dr. felt that the symptoms were highly suggestive of CTS. He performed an EMG/NCV study which revealed moderate-to-severe bilateral CTS. The patient was recommended right carpal tunnel release (CTR). Dr. placed the patient at clinical MMI as of August 22, 2003, and assigned 5% whole person impairment (WPI) rating (for the April 16, 2002, injury).

In 2005, , M.D., performed a peer review and rendered the following opinions: Ongoing medical treatment was not necessary; there was no need for future

treatment; previous treatment was excessive; and degenerative conditions contributed to her complaints.

In 2008, , M.D., performed a peer review and rendered the following opinions: The compensable diagnosis regarding the xx/xx/xx injury was right CTS. She had long conservative treatment with wrist splinting, non-steroidal anti-inflammatory drugs (NSAIDs), Neurontin, pain medications, IM cortisone, limitation of activities, PT, home exercises, and multiple carpal tunnel cortisone injections. Based on the treatment course, recommendation of right CTR would be reasonable. Current medications were not needed. There was no indication of aggravation of cervical injury by the xx/xx/xx injury.

In May, the patient was seen by , M.D., a hand surgeon. She reported that over the last six years she had been treated with injections and medications. She had pain, hypoesthesias, dyesthesias, and loss of strength and these had been progressive over the last several years. EMG/NCV study in 2003 had revealed neuropathy of the hand and chronic compression of the carpal tunnel.

Examination revealed positive Tinel's, Allen's, and Phalen's tests on the right and diminished two-point discrimination. Dr. assessed CTS and stated that the patient's EMG/NCV appeared to be quite old and recommended re-assessing validity of the studies or at least the progression or regression of the symptoms with a new study. He stated that based on the history and all progressive findings, the patient would be treated with decompression of the CTS rather than a block.

On May 28, 2008, , D.O., denied the request for EMG/NCV study of the upper extremities with the following rationale: *"Claimant has had conservative treatment including splinting, medications, injections, physical therapy, and activity modification. Prior electrodiagnostic testing (06/19/03) reveals moderate- to-severe bilateral CTS. Results are not provided for review. Tinel's is positive and Phalen's is negative. Necessity of both EMG and NCV is not established. There is no indication of need to rule out cervical radiculopathy. Prior NCV noted moderate-to-severe bilateral CTS. It is not clear how repeat testing will affect the treatment plan."*

On June 30, 2008, Dr. denied the appeal for EMG/NCV study of the upper extremities with the following rationale: *"The claimant reports that over the last six years, she has been treated with injections and analgesics. She has been diagnosed with CTS. She reports pain, hypoesthesia, and loss of strength. Symptoms are progressive over the last few years. EMG has been previously performed (2003) showing chronic compression of the carpal tunnel. Physical examination shows positive Tinel's sign. Allen's and Phalen's tests are also positive. Recommended treatment includes repeat EMG testing to reassess the validity of studies or to determine the progress or regress of symptoms. Without additional information, the requested EMG is not supported at this time."*

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

Repeat EMG is not addressed well in ODG, however, with progression of the symptoms standard of care and AAEM guidelines recommend repeat studies.

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

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION) AAEM**

TWENTY PLUS YEARS OF TRAINING AND EXPERIENCE