SENT VIA EMAIL OR FAX ON
Apr/13/2009

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/07/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Upper EMG / NCV

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Chiropractor
AADEP Certified
Whole Person Certified
TWCC ADL Doctor
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy

REVIEW OUTCOME:

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

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 2/26/09 and 3/3/09
3/26/09
Chiro 1/7/09 and 2/11/09
Dr. 4/15/08

PATIENT CLINICAL HISTORY SUMMARY
The injured worker was injured on xx/xx/xx as a result of a work related injury. Records indicated that the injured employee underwent a cervical fusion on 5-30-2007 and a shoulder surgery on 9-2006. The injured employee underwent an EMG/NCV of the bilateral upper extremities on 4-15-2008. EMG/NCV reported findings that were suggestive of moderately severe carpal tunnel syndrome bilaterally, no signs of acute or chronic radiculopathy or

polyneuropathy. The injured employee had a follow-up visit with Dr. on 1-07-2009 and again on 2-11-2009. According to the records the injured employee was assigned a 22% WBI rating by Dr. on 1-26-2009. Dr. stated in his report on 1-07-2009, that the injured employee “was taking a shower recently and felt a pop in the neck/trap region on the left and since then he has had increased difficulty with weakness in the left shoulder along with pain. He can actively reproduce that symptom of electrical shock when he reaches for something.” Dr. noted on 2-11-2009, the injured employee has a negative Tinel’s and Phalen at each wrist.” Dr. reported that the injured employee was experiencing numbness and pain in the hand, let arm, and shoulder. Tinel’s is positive at the left cubital tunnel and decreased pinwheel to the left fifth digit and possible motor weakness on the right.
Dr. is now requesting an EMG/NCV of the upper extremities to evaluate and rule-out active radiculopathy and left ulnar neuropathy.

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

For all the reasons stated above, the injured employee currently does meet the OD guideline for a repeat EMG/NCV of the upper extremities.

ODG states that (see below)

1. 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.

2. NCS is recommended in patients with clinical signs of CTS

3. Additional testing may be indicated in patients with a differential diagnosis which includes peripheral neuropathy, cervical radiculopathy, brachial plexopathy, or more proximal median neuropathy.

Frequency of Electrodiagnostic Testing in a Given Patient

There are many clinical situations where good medical management requires repeat testing, such as in the following examples

1. Second diagnosis. Where a single diagnosis is made on the first visit, but the patient subsequently develops a new set of symptoms, further evaluation is required for a second diagnosis that treatment can begin.

2. Inconclusive diagnosis. When a serious diagnosis (e.g., ALS) is suspected but the results of the needle EMG/NCS examination are insufficient to be conclusive, follow-up studies are needed to establish or exclude the diagnosis.

3. Rapidly evolving disease. Initial EDX testing in some diseases may not show any abnormality (e.g., Guillain-Barré syndrome) in the first 1 to 2 weeks. An early diagnosis confirmed by repeat electrodiagnosis must be made quickly so that treatment can begin. Follow-up testing can be extremely useful in establishing prognosis and monitoring patient status.

4. Course of the disease. Certain treatable diseases such as polymyositis and myasthenia gravis follow a fluctuating course with variable response to treatment. The physician treating such patients needs to monitor the disease progress and the response to therapeutic interventions. The results of follow-up evaluations may be necessary to guide treatment decisions.

5. Unexpected course or change in course of the disease. In certain situations, management of a diagnosed condition may not yield expected results or new, questionably related problems may occur (e.g., failure to improve following surgery for radiculopathy). In these instances, reexamination is appropriate.

6. Recovery from injury. Repeat evaluations may be needed to monitor recovery, to help establish prognosis, and/or to determine the need for and timing of surgical intervention (e.g., traumatic nerve injury).

Repeat EDX consultation is therefore sometimes necessary and, when justifiable, should be reimbursed. Reasonable limits can be set concerning the frequency of repeat EDX testing per year in a given patient by a given EDX consultant for a given diagnosis. The following numbers of tests per 12-month period per diagnosis per physician are acceptable:

1. Two tests for carpal tunnel-unilateral, carpal tunnel-bilateral, radiculopathy, mononeuropathy, polyneuropathy, myopathy, and NMJ disorders.

2. Three tests for motor neuronopathy and plexopathy.

These limits should not apply if the patient requires evaluation by more than 1 EDX consultant (i.e., a second opinion or an expert opinion at a tertiary care center) in a given year or if the patient requires evaluation for a second diagnosis in a given year.

OD

Carpal Tunnel Syndrom

For suspected carpal tunnel syndrome (CTS), bilateral median motor and sensory NCSs are often indicated.

Additional testing may be indicated in patients with a differential diagnosis which includes peripheral neuropathy, cervical radiculopathy, brachial plexopathy, or more proximal median neuropathy.

Radiculopath

Radiculopathies cannot be diagnosed by NCS alone; needle EMG must be performed to confirm a radiculopathy.

Electromyography (EMG) 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.

Timing: Timing is important as nerve root compression will reflect as positive if active changes are occurring. Changes of denervation develop within the first to third week after compression (fibrillations and positive sharp waves develop first in the paraspinals at 7-10 days and in the limb muscles at 2-3 weeks), and reinervation is found at about 3-6 month

Acute findings: Identification of fibrillation potentials in dennervated muscles with normal motor unit action potentials (usually within 6 months of symptoms: may disappear within 6

weeks in the paraspinals and persist for up to 1-2 years in distal limbs)

Chronic findings: Findings of motor unit action potentials with increased duration and phases that represent reinnervation. With time these become broad, large and polyphasic and may persist for years

Anatomy: The test primarily evaluates ventral (anterior) root function (motor) and may be negative if there is dorsal root compression (sensory) only. Only C4-8 and T1 in the neck region have limb representation that can be tested electrodiagnostically. The anatomic basis for this lies in the fact that the cervical nerve roots have a motor and a sensory component. It is possible to impinge the sensory component with a herniated disc or bone spur and not affect the motor component. As a result, the patient may report radicular pain that correlates to the MRI without having EMG evidence of motor loss.

Paraspinal fibrillation potentials: May be seen in normal individuals and are nonspecific for etiology. The presence of these alone is insufficient to make a diagnosis of radiculopathy and they may be absent when there is a diagnosis of radiculopathy secondary to sampling error, timing, or because they were spared. They may support a diagnosis of radiculopathy when corresponding abnormalities are present in the limb muscles

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.

H-reflex: Technically difficult to perform in the upper extremity but can be derived from the median nerve. The test is not specific for etiology and may be difficult to obtain in obese patients or those older than 60 years of age.

(Negrin, 1991) (Alrawi, 2006) (Ashkan, 2002) (Nardin, 1999) (Tsao, 2007) See Discectomy-laminectomy-laminoplasty. (Surface EMG and F-wave tests are not very specific and therefore are not recommended. For more information on surface EMG, see the Low Back Chapter.)

Nerve conduction studies (NCS) Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective.

Nerve conduction studies (NCS) Recommended in patients with clinical signs of CTS who may be candidates for surgery. Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS). Carpal tunnel syndrome must be proved by positive findings on clinical examination and should be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Nerve conduction studies should be done by a qualified technician working directly under the supervision of a physician. (Utah, 2006) See Electrodiagnostic studies; and Portable nerve conduction devices.

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

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)