

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 08/17/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1. EMG/NCV on left upper extremity
2. EMG/NCV on right upper extremity

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

The TMF physician reviewer is a board licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the EMG/NCV on left upper extremity and EMG/NCV on right upper extremity are not medically necessary to treat this patient's condition.

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

- Information for requesting a review by an IRO – 07/28/09
- Letter of determination from – 07/02/09, 07/07/09
- Rebuttal of denial for EMG/NCV testing from Dr. – 07/09/09
- Preauthorization Request for physical medicine rehab from Dr. – 06/25/09
- Follow up evaluation by Dr. – 06/23/09
- Decision and Order by – 06/16/09
- Preauthorization Request for EMG/NCV upper extremities by Dr. – 06/25/09

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

This patient sustained a work related injury on xx/xx/xx when he was unloading a pallet of paper from a truck and he slipped and fell onto his left side on the concrete ground. The patient complains of increased pain over the cervical region that travels to the right chin and right shoulder. Follow-up evaluation 06/23/09 revealed subjective complaints of tingling over the cervical region that travels to the right chin and right shoulder. Pain is experienced over this region rated at 3/1. The patient lists provocative activities as repetitive extension and right rotation of the cervical spine. Objective findings reveal palpatory tenderness over the cervical and upper thoracic paravertebral and paraspinal musculature. Manual muscle testing was grade 5/5. Deep tendon reflex is graded +2 for the upper extremities. Sensory examination is unremarkable and cervical range of motion is somewhat diminished. The treating chiropractor is recommending EMG/NCV studies for the right and the left upper extremities.

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

The ODG's allow for EMG/NCS in certain situations such as cervical radiculopathy and Carpal Tunnel Syndrome. There are clear and specific guidelines for these conditions. The ODG's do not specifically address the use of EMG/NCS to rule out diabetic neuropathy as it pertains to an on the job injury. This patient does not have any subjective symptoms or objective/clinical findings that would lead a prudent clinician to suspect either cervical radiculopathy and/or carpal tunnel syndrome. There is no clinical justification to order such electrodiagnostic testing based upon the injuries he received on the job. Therefore, it is determined that that there is not sufficient documentation to clinically justify the requested services.

### **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)