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Notice of Independent Review Decision

DATE OF REVIEW: March 3, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV study 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:

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (12/23/08 - 01/19/09)
- Office visits (08/29/03 – 12/11/08)
- Diagnostics (11/14/03 – 12/12/06)

ODG Criteria have been used for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who fell off a chair landing on her hip and then crashed onto her left side. She experienced left-sided cervical pain with radiation into the back of her left arm.

Initially, the patient was treated by M.D., for severe left-sided cervical pain radiating into left arm and numbness and tingling as well as increased lower back pain. X-rays of the cervical spine were unremarkable. X-rays of the lumbar spine showed a solid fusion at L5-S1 and possible small pseudoarthrosis at L4-L5. Examination showed positive Spurling's test. Dr. assessed left-sided cervical radiculopathy. Magnetic resonance imaging (MRI) of the cervical spine

demonstrated a disc protrusion at C5-C6 off the posterior lateral corner on the left causing some foraminal stenosis. Dr. discussed treatment options including physical therapy (PT), oral steroids, and epidural steroid injection (ESI). However, in September, the patient had deterioration of the neurologic function in the upper extremities. On September 27, 2003, Dr. performed emergency anterior C5-C6 total discectomy with left-sided foraminotomy and anterior interbody fusion. Post surgery, tingling and numbness in the arms improved, but she began having pain in her left arm. Dr. assessed lateral epicondylitis and administered a steroid injection in the left elbow. He ordered electromyography (EMG) of the left arm.

M.D., evaluated the patient for radiating low back pain. He assessed lumbar discopathy, mechanical low back pain, and coccydynia and treated her with Ultracet and Zanaflex.

In November, EMG/nerve conduction velocity (NCV) of the left upper extremity revealed mild left carpal tunnel syndrome (CTS). X-rays of the elbow were unremarkable. Dr. treated her with anti-inflammatory medications while Dr. performed left C5 and C6 selective nerve root injections. The patient noted some relief for a brief period of time. She continued to have pain in her left arm radiating to first three fingers. Dr. ordered EMG/NCV of the left hand. Dr. assessed cervical radiculitis and post cervical laminectomy syndrome and ordered computerized tomography (CT) myelogram of the cervical spine.

In March 2004, M.D., performed a medical evaluation and rendered following opinions: (1) Effects of the injury had not resolved and she had sequelae from the injury. (2) Current treatment and medications were reasonable and necessary. (3) She would need another EMG/NCV. (4) The patient was unable to return to work, but possibly would be able to perform sedentary duties.

EMG/NCV study of the left arm revealed cervical radicular disease involving C6 and mild CTS. Dr. decreased medications and recommended functioning at a higher level. He prescribed galvanic stimulating unit. In July, Dr. noted the patient was neurologically intact and there was nothing further to offer.

On August 4, 2004, M.D., assessed clinical maximum medical improvement (MMI) and assigned 25% whole person impairment (WPI) rating. She recommended trial of acupuncture treatment and trigger point injections (TPIs).

Dr. noted diffuse tenderness over the cervical paraspinal segments and positive Tinel's at the wrists bilaterally. He prescribed Skelaxin, hydrocodone, and Medrol Dosepak; performed a cervical epidural steroid injection (ESI) without much relief of pain; and referred the patient for evaluation of CTS.

In March 2005, MRI revealed status post a C5-C6 ACDF with hardware in excellent condition. In September, Dr. noted that the patient had developed depression and attempted suicide. She was seeing Dr. for counseling. In January 2006, Dr. noted the patient had undergone a cholecystectomy. She continued to have neck pain radiating to her shoulder and to the left upper extremity. Dr. treated her with Neurontin, Lyrica, Norco, Ultram, and Kepra.

In a functional capacity evaluation (FCE) in July 2006, the patient qualified at a sedentary physical demand level (PDL). The evaluator recommended aquatic program.

MRI of the cervical spine revealed focal protrusion of the far posterolateral disc on the right and left at C6-C7, more on the left producing extradural nerve root compression within the medial neural foramina.

Throughout 2008, there were multiple follow-ups with Dr. for medications management.

In December 2008, M.D., an orthopedic surgeon, evaluated the patient for complaints of neck pain radiating into the left shoulder and left arm. Examination was limited due to the patient's anxiety and pain. There was decreased and painful cervical ROM. X-rays of the cervical spine revealed fusion at C5-C6 with mild arthritic changes. Dr. assessed cervicgia and cervical radiculopathy. He ordered EMG/NCV of the upper extremities, cervical myelogram CT scan, and continued follow-up with Dr. for pain management.

On December 23, 2008, request for EMG/NCV of upper extremities was not authorized with the following rationale: *"An EMG/NCV will not provide any anatomical findings that would be a definite basis for the alleged symptoms. The patient needs to have an anatomical study to make decision regarding surgical pathology."*

On January 19, 2009, an appeal for EMG/NCV of upper extremities was denied with following rationale: *"Fifteen pages of records reviewed. In those available and reviewed medical records there is no discernible documentation from the requester of record, Abdul Kadir (discipline not specified). Noteworthy is the absence of the name of the requester of record in the letterhead on which the only available clinical note was produced based on this fact, the request as submitted is not reasonable and medically necessary."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. THERE ARE NO ADDITIONAL RECORDS SUPPORTING THE NEED FOR ANOTHER EMG/NCS. IT IS WELL DOCUMENTED THE PATIENT HAS A RADICULOPATHY AND ANOTHER WILL ADD NOTHING TO THE CURRENT DIAGNOSIS OR DECISION MAKING AS IT OFFERS NO ANATOMICAL FINDINGS.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES AND TWENTY PLUS YEARS OF TRAINING.