

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: November 9, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV study right upper extremity

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

Board Certified Orthopaedic surgeon

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (09/21/09 - 09/29/09)
- Office visits (07/10/09 - 09/16/09)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his right upper extremity while pulling a lawn mower on xx/xx/xx.

In July 2009, M.D., noted the following history: *After the injury, the patient developed pain in his finger with subsequent triggering as well as pain in forearm and elbow. He was sent for physical therapy (PT) for a month with no improvement. He also underwent two injections on the medial side of his elbow with eight to 15 days of relief. He reported numbness and tingling mainly in his middle and ring finger associated with swelling on the anterior aspect of his proximal forearm. He had 80% pain relief with diagnostic radial nerve anesthetic block. Computerized tomography (CT) scan revealed osteoarthritic changes in*

the lateral compartment and a small loose body in the olecranon fossa. Currently, he presented for chronic pain in the right elbow, forearm, and hand. With repetitive gripping or pulling activities, he would develop a cramp very quickly on his flexor muscles of right forearm and felt popping or something shifting around his cubital tunnel while stretching his arm upward. History was positive for hypertension. Examination revealed an overweight male with moderate tenderness over the medial epicondyle, mild tenderness over the lateral epicondyle, mild pain at the lateral elbow with resisted wrist extension, mild pain at the medial elbow with resisted wrist flexion, positive elbow flexion and ulnar nerve compression tests and positive radial tunnel compression test. Dr. assessed median, ulnar, and radial nerve lesions; medial and lateral epicondylitis; and osteochondropathy.

On July 22, 2009, Dr. performed right radial tunnel release, right extensor tenotomy, and application of long-arm splint. Postoperatively, the patient developed mild incisional swelling and was given a cock-up splint. He was recommended PT.

In August, Dr. noted scars consistent with previous surgery and ordered electromyography/nerve conduction velocity (EMG/NCV) studies to evaluate for any worsening in the medial elbow and ulnar nerve distribution.

On September 16, 2009, the patient complained of persistent medial epicondyle pain of a moderate-to-severe nature and numbness in the morning and tingling in the mornings and night on the ulnar aspect of hand and fingers. Examination revealed scars consistent with previous surgeries, mild tenderness of the medial epicondyle and the flexor musculature, subluxation of the ulnar nerve with pain, and positive ulnar nerve compression test and Tinel's test with radiation to the hand and small finger. Dr. assessed trigger finger and tenosynovitis of radial styloid and ordered EMG/NCV study to document any worsening of the ulnar nerve function.

Per utilization review dated September 21, 2009, the request for EMG/NCV of the right upper extremity was denied with the following rationale: *"As per medical records, the patient is status post radial tunnel release with extensor tenotomy on July 22, 2009. Patient continues to complain of medial epicondyle pain of moderate-to-severe nature, usually in the mornings with numbness and tingling. Provider requests for an EMG/NCV of the right upper extremity to document any worsening of the ulnar nerve function. Current ODG do not recommend the use of electrodiagnostic studies for a clear diagnosis of nerve impingement if subjective, objective and imaging findings suggest obvious radiculopathy. Previous EMG/NCV study was unremarkable. Response to exhaustion of other conservative therapies such as medications such as PT was not objectively documented through VAS pain scales and PT progress notes. Hence the medical necessity of the requested service is not established"*.

Per utilization review dated September 29, 2009, an appeal for EMG/NCV of the right upper extremity was denied with the following rationale: *"The clinicians own note indicates the claimant is improving with only morning numbness and stiffness with tingling. The clinician has failed to demonstrate the clinical necessity for the requested procedure. ODG does not support this procedure in this setting. I discussed the case with P.A. Dr. was not available however he*

was able to speak to me on his behalf. They are requesting a repeat EMG after radial tunnel surgery. PA not clear on physical findings and was not clear if there were any changes in physical exam. Without further information this request is not indicated.”

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

The EMG and nerve conduction study may be reasonable to evaluate for evidence of peripheral nerve compression of the ulnar nerve at the cubital tunnel. The claimant reportedly has worsening symptoms after a radial tunnel release and the symptoms are not isolated to the radial nerve, rather the symptoms seem to be more consistent with ulnar nerve pathology. Given the new symptoms following the claimant's surgery, it would be reasonable to evaluate the ulnar nerve with electrodiagnostics studies.

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

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, Forearm , Wrist and Hand : Electromyography (EMG) / Electrodiagnostic studies (EDS)

Recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. ([Bienek, 2006](#)) Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), and possibly the addition of electromyography (EMG).

Neck and upper Back : Electromyography (EMG)

Recommended (needle, not surface) as an option in selected cases.

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.

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.