

**MRI**

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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/6/2009

**PRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of a repeat EMG and NCV Bilateral Upper Extremities and Muscle Testing Bilateral Upper Extremities (95900, 95903, 95861).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years and performs this service in his office.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a repeat EMG and NCV Bilateral Upper Extremities and Muscle Testing Bilateral Upper Extremities (95900, 95903, 95861).

A copy of the ODG was not provided by the Carrier or the URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured employee sustained an injury while in the course of lifting to the lower cervical and upper thoracic spinal area that occurred xx/xx/xx. The patient experienced pain in the upper back and lower neck area and underwent a significant period of treatment, including therapy, medications, and injection treatment, and is currently under consideration of surgery by M.D., involving abnormal levels at the C7-T1 on MRI evaluation. The surgery proposed is an anterior cervical microdiscectomy with interbody fusion using bone allograft and cage.

The patient is indicated to have not received any benefit from his preceding

treatments, which have been done over a two-year period of time. The patient has had right upper extremity symptoms and associated neck and headache pain. A recent MRI did show evidence of the following:

1. Multifactorial degenerative changes at C3-4 produce moderate central canal stenosis and moderate to advanced bilateral foraminal stenosis, left greater than right.
2. Right foraminal C7-T1 disk herniation.
3. Milder degenerative changes at the remaining levels without otherwise radiographically significant central canal or foraminal stenosis.

This test, dated 06/21/07, performed at the Radiological Association, is noted to be essentially unchanged from the more recent testing.

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

The *ODG* for cervical EMG and nerve conduction studies indicates that there is moderate sensitivity and highly specific information obtainable from this time of testing. It is not noted, however, that these findings may be predictive of surgical outcome in cervical surgery and that patients may still benefit, even in the absence of EMG findings, of nerve root impingement. The cervical area differs significantly from the lumbar spine, where EMG findings are noted to be highly correlative with symptoms. In relationship to nerve conduction studies, these are not recommended. The *ODG* notes minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of a radiculopathy. Additionally, there is no specific documentation provided that the operating surgeon has included a repeat EMG and nerve conduction study based on clinical findings or as part of a treatment plan.

In relationship to the manual muscle testing, this muscle testing has already been accomplished in Dr. 's most recent examination. A duplication of this examination is not medically reasonable and necessary.

**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)