

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 11/23/2010  
**IRO CASE #:**

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

Appeal electrodiagnostic study RUE, 95860 & 95903

**QUALIFICATIONS OF THE REVIEWER:**

Physical Med & Rehab, Pain Management

**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)

Appeal electrodiagnostic study RUE, 95860 & 95903 Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Notice to by, dated 11/4/2010
2. IRO request form dated 11/4/2010
3. Request form by author unknown, dated 11/4/2010
4. Preauthorization determination dated 10/28/2010
5. Preauthorization determination dated 10/16/2010
6. Preauthorization determination dated unknown
7. Fax page dated 11/5/2010
8. Fax page dated 11/4/2010
9. Request for a review by author unknown dated 11/4/2010
10. Request form by author unknown dated 11/4/2010
11. Review is based on medical necessity by author unknown dated 10/6/2010 & 10/28/2010
12. Email, dated 10/5/2010 & 10/27/2010
13. Form by author unknown dated 9/29/2010
14. Letter by, MD dated 9/29/2010
15. Operative report by, MD dated 6/28/2010 & 9/10/2010
16. Office visit by author unknown dated 2/25/2010
17. MRI cervical spine without contrast by, MD dated 2/24/2010
18. C spine 5 views by MD dated 2/24/2010
19. Operative report by, MD dated 11/9/2009
20. Procedure note by, MD dated 6/8/2009
21. Medical examination by, MD dated 1/23/2008
22. Notes by, MD dated 1/22/2008 to 9/23/2010
23. DEC evaluation by, MD dated 9/29/2006

24. Isometric strength assessment by author unknown dated 9/29/2006
25. Letter by, MD dated 3/26/2006
26. MRI cervical spine without contrast by, MD dated 9/17/2004
27. Progressive performance summary by author unknown dated unknown
28. The ODG Guidelines were not provided

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The documentation reports a female who reported an injury on xx/xx/xxxx. The injured employee presented with complaints of neck pain and right upper extremity numbness. An exam on 9-23-10 reported right upper extremity sensory loss along the volar forearm, 4/5 strength to the right hand grip, intrinsics and APB. Discussion was made regarding need of neurosurgical referral. A past MRI of the cervical spine dated 2/2010 reported findings of degenerative disc disease at C6-7 with no report of nerve root entrapment. The injured employee is status post cervical fusion in 2002. Exam findings were discussed regarding right upper extremity weakness and sensory loss that has been chronic with no appreciation of progressive focal neurological deterioration.

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

Based upon the available documentation and the ODG Guidelines, I respectfully do not recommend the request for electrodiagnostic study right upper extremity (RUE) 95860 & 95903 to be reasonable or medically necessary. The documentation supports a long history of neck pain and right upper extremity referral pain with focal neurological deficits to the right upper extremity in the long term. There is no objective evidence of acute progressive focal neurological deficits appreciated in the documentation reviewed. The injured employee had a diagnosed history of cervical radiculopathy and is status post cervical fusion surgery with no appreciation of acute focal neurological deterioration since the MRI performed in 2/2010 that was negative for nerve root entrapment. The recommendation is to uphold the previous denial.

**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)