



Notice of Independent Review Decision

DATE OF REVIEW: July 8, 2010

IRO Case #:

Description of the services in dispute:

Items in dispute EMG upper extremity (#95860, #95900, #95861, #95903, #95904, and #95934)

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer is a member of the American Academy of Orthopaedic Surgeons and the Society of Military Orthopaedic Surgeons. This reviewer has been in active practice since 2005.

Review Outcome

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

The clinical documentation provided for review does not support the requested EMG/NCV prescribed for the patient on 4/21/10. The clinical notes do not provide an in depth rationale on why electrodiagnostic studies are being requested for the patient. The recent physical exams demonstrate evidence consistent with radiculopathy and it is unclear how EMG/NCV studies would provide additional clinical information that would guide treatment for the patient. The most recent notes recommend epidural steroid injections at C6-7; however, there is no discussion regarding electrodiagnostic studies that address the concerns outlined in the submitted utilization reviews. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, the requested EMG/NCV studies are not medically necessary and the prior denials are upheld.

Information provided to the IRO for review

Records from the state:

Company Request for IRO 6/22/10, 4 pages

Request for Review by and Independent Organization 6/10/10, 3 pages

Records from xxxxxxxx

Patient clinical history [summary]

The patient is a male who sustained an injury on xx/xx/xx when he fell on a conveyor belt. The patient was seen in the emergency room on the date of injury with complaints of injury to the right cheek, frontal head, left arm, and right foot. The CT of the head performed on 9/28/09 demonstrates right facial soft tissue contusion/hematoma. No facial bone fracture is identified. There is a suspected remote infarct in the left cerebellar hemisphere. The radiographs of the right forearm performed 9/28/09 demonstrate evidence of arterial calcifications, suggestive of diabetes or renal failure. No fracture is seen. The patient is assessed with facial contusion. The patient saw Dr. on 11/10/09. The patient states he was caught on a conveyor belt. He was knocked on to the belt, which pushed his head onto a metal piece. He complains of pain to the forehead on the right side, right shoulder pain, and right arm pain. He also reports dizziness with rapid head turn. The patient has a history of type 2 diabetes. The physical exam reveals the head is normocephalic and atraumatic. There is pain with abduction and elevation of the right shoulder. There is decreased grip in the right hand. The patient is assessed with right shoulder pain, cephalgia, and paresthesia. The patient is recommended for radiographs of the cervical spine and shoulder. He is prescribed Daypro and Zanaflex.

The MRI of the right shoulder performed on 1/04/10 demonstrates acromioclavicular osteoarthritis. There is type II acromion that slopes downward laterally with anterior impingement. There are tears of the supraspinatus and infraspinatus tendons. There are partial tears of the distal aspect of the subscapularis tendon. The patient returned to Dr. with continued right shoulder pain with range of motion. There is occasional pain and weakness into the right hand. The patient complains of joint pain, back pain, arthritis, and muscle aches. He reports occasional right-sided headaches on occasion. Physical exam reveals joint tenderness and decreased range of motion of the right shoulder. The patient is prescribed Relafen 500mg and Robaxin 500mg. He is referred for orthopedic evaluation. The patient saw Dr. on 1/11/10 with complaints of right shoulder pain. He reports pain with forward flexion, abduction, and internal rotation. He denies radicular complaints, but does complain of some neck pain. Physical exam reveals full active and passive range of motion of the right shoulder with mildly tender impingement signs. There is tenderness with resisted abduction and external rotation. The patient is assessed with a full thickness rotator cuff tendon tear with some co-existent bursitis of the subacromial area and acromioclavicular joint osteoarthritis. The patient received a right shoulder cortisone injection. The patient returned to Dr.

on 1/25/10. He states he did not get significant improvement from the injection. Dr. opines that the patient has a partial tear of the rotator cuff. The patient is recommended for 12 sessions of physical therapy. The patient was seen for initial physical therapy evaluation on 1/28/10. The patient demonstrates severe dysfunction due to the right shoulder. There are impairments in shoulder strength, pain with palpation, poor postural control of the right shoulder girdle, and radiating arm pain. Disabilities of the Arm, Shoulder, and Hand score are 62% indicating severe disability. The patient was re-evaluated on 3/01/10. The patient has attended 11 sessions of physical therapy. The patient demonstrates improvement in his Disabilities of the Arm, Shoulder, and Hand score from 62% to 45%. Pain has decreased by

50%. Range of motion has improved by
25%. Strength is improved by 1 muscle grade. Postural control is improved. The patient is recommended for 8 additional sessions of physical therapy.

The patient saw Dr. on 3/09/10. The patient complains of right shoulder and neck pain. He is also now reporting right eye pain. The patient reports no improvement in his shoulder pain with physical therapy. Physical exam reveals pain with internal and external rotation of the right shoulder with decreased grip strength of the right hand. The patient is recommended to follow up with orthopedic doctor. The patient returned to Dr. on 3/15/10 with continued pain complaints. Dr. opines that the patient's main problem is cervical and radicular. The patient is recommended

for MRI of the cervical spine and a spine surgery consult. He is also referred to an Ophthalmologist.

The patient saw Dr. on 3/24/10 with complaints of right shoulder and neck pain, as well as headache. Physical exam reveals tenderness to palpation to the base of the neck on the right side. There is pain upon rotation to the right. Full range of motion is noted. Exam of the extremities reveals pain with abduction and elevation to 90 degrees. The patient is recommended for MRI of the cervical spine. The patient is prescribed Robaxin 500mg. The patient saw Dr. on 3/31/10 with complaints of blurry vision of the right eye and chronic discomfort. The patient states he has been diabetic for 15 years, and his last exam was 4 years ago. The patient is assessed with increased vitreous syneresis of the right eye and diabetic retinopathy.

The MRI of the cervical spine performed on 4/06/10 demonstrates multiple disc herniation and levels of degenerative spondylosis as well as degenerative changes at C1-2 articulation. There are variable degrees of central canal stenosis and foraminal compromise at multiple levels. MRI of the brain performed 4/06/10 demonstrates an area of encephalomalacia from a prior ischemic event in the left cerebellum. There is no acute or subacute process intracranially. There are degenerative changes in the atlantoaxial articulation producing narrowing of the upper cervical spinal canal with

a borderline canal diameter of 9mm. The patient saw Dr. on 4/13/10 with continued pain complaints. Physical exam reveals decreased sensation to pain of the third digit. The patient is prescribed Neurontin 100mg and Vicodin 5/500mg. He is referred to a pain clinic for possible injections. The patient saw Dr. on 4/21/10 with complaints of neck and right arm pain. He states he was on a conveyor belt when someone turned it on. A metal object hit him in the side of his head knocking him out. The patient reports neck pain that radiates into the right arm down into the index and middle finger. He rates the pain at 8 out of 10 on the visual analogue scale (VAS)

scale with some weakness. He has tried 10 sessions of physical therapy with minimal improvement.

He also had a shoulder injection that provided minimal benefit. The patient's medical history is significant for non-insulin dependent diabetes. Physical exam reveals strength is 4/5 with finger grasp on the right and 4/5 with arm abduction. There is decreased sensation on the right

in a C7 distribution. He is slightly hyporeflexic in the right biceps. There is minimal spinous process tenderness at C6–7 with palpation. There is minimal pain with cervical flexion and extension. Multiple trigger points are identified in the trapezius and cervical paraspinal musculature. The patient is assessed with cervical radiculopathy, multiple cervical disc bulges, and cervical spondylosis. The patient is recommended for cervical epidural steroid injection at C6–7. There is a prescription by Dr. dated 4/21/10—ordering an EMG/NCV of the upper extremity.

The request for EMG/NCV of the upper extremity was denied by utilization review on 5/05/10 because the request included nerve conduction velocity studies. The patient saw Dr. on 5/10/10 with complaints of neck and right arm pain. The physical exam reveals decreased sensation on the right in a C7 distribution. There is minimal spinous process tenderness at C6–7 with palpation. There is minimal pain with cervical flexion and extension. The patient is recommended for cervical epidural steroid injection. The patient received cervical transluminal epidural steroid injection at C6–7 on 5/11/10. The request for the EMG/NCV of the upper extremity was denied by utilization review on 6/02/10 due to lack of documentation that demonstrates failure of conservative care, as well as no evidence of progressive neurologic deficits.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

Official Disability Guidelines, Online Version, Neck and Upper Back Chapter Nerve conduction studies (NCS) not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Official Disability Guidelines, Online Version, Neck and Upper Back Chapter.