



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC NETWORK

DATE OF REVIEW: 06/10/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat Needle EMG/NCV RUE

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

Board Certified in Anesthesiology with Certificate of Added Qualifications in Pain Medicine

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Repeat Needle EMG/NCV RUE – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was loading a piece of equipment onto a slide bed trailer, when he slipped off, causing his right arm to get caught on the headache rack. An MRI of the right elbow showed mild to moderate chronic appearing lateral epicondylitis, as well as a minimal intrasubstance tear. There was small fluid adjacent to the ulnar nerve without a definitive signal abnormality within the nerve itself. There was minimal joint effusion. A Nerve Conduction and Electromyography was performed which indicated a normal study of the right upper extremity. A cervical MRI indicated multilevel cervical spondylosis, with the

most severe level being at the right C6-C7 level. There was a large right uncinat spur disc herniation complex causing essentially complete stenosis of the right foramen. It was indicated by Dr. the claimant was at Maximum Medical Improvement (MMI) and did not believe that any other intervention was warranted at that point. The claimant was then scheduled for an MMI evaluation with Dr.. Dr. evaluated the claimant for the purpose of an impairment rating; however, requested a repeat electrodiagnostic test prior to calculating the impairment.

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

None of the initial documentation by Dr. or Dr. documented any injury to the cervical spine nor any symptoms related to the neck for cervical radicular pain. Additionally, the patient's elbow and right upper extremity symptoms were not supported by either physical examination evidence of radiculopathy on any examination nor by electrodiagnostic evidence of radiculopathy based on the entirely normal electrodiagnostic studies by Dr., which she termed "extensive." The MRI scan findings on 09/21/09 were, in all medical probability, indicative of long standing degenerative changes. I base this upon the fact that the claimant had at least four levels of bilateral significant facet spurring, which is clearly indicative of ordinary disease of life degeneration, as well as evidence of right paracentral disc herniation/facet spurs, also more medically likely than not indicative of an ordinary disease of life degenerative condition. The patient's symptoms were not consistent with the evidence of a very large right C6-C7 facet spur/disc herniation complex.

The request for repeat electrodiagnostic studies is not medically reasonable or necessary to treat or diagnose the patient's clinical condition. In fact, there has been no interval change in the patient's clinical condition or physical examination since the MRI scan and initial electrodiagnostic studies were performed. There is no medical reason or necessity for repeating electrodiagnostic studies absent an interval change in clinical condition or examination. Therefore, since there has been no interval change in the patient's clinical condition, complaints, or physical examination since the initial entirely normal electrodiagnostic study, there is no medical reason or necessity for the requested repeat electrodiagnostic study of the right upper extremity. Therefore, the recommendations for non-authorization of this request by the two previous physician reviewers are upheld. The requested repeat needle EMG/NCV of the right upper extremity is not medically reasonable or necessary nor likely to in any way change the patient's clinical course.

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)