



Notice of Independent Review Decision

DATE OF REVIEW:

04/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV Bilateral upper extremities, 95861 x1 unit, 95903 x6 units, 95904 x6 units, and 99244; office consultation.

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

Board Certified Chiropractor

REVIEW OUTCOME

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

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.

The medical necessity for the requested items under review EMG/NCV; bilateral upper extremities, 95861 x1 unit, 95903 x6 units, 95904 x6 units, and 99244; office consultation is not established.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 04/13/10 letter from Dr., Physicians Diagnostic Services
- 04/12/10 MCMC Referral
- 04/12/10 Notice of Assignment of Independent Review Organization, , DWC
- 04/12/10 Notice To xxxx, xxxx Of Case Assignment, , DWC
- 04/09/10 Confirmation Of Receipt Of A Request For A Review, DWC
- 04/08/10 Request For A Review By An Independent Review Organization
- 04/08/10 Preauthorization Review Summary,
- 03/31/10 Preauthorization Advisor Review Form, , LVN, (with handwritten notes dated 04/06/10 and 04/07/10)
- 03/30/10 Preauthorization Review Summary,
- 03/30/10 Request For Reconsideration Appeal To Pre-Authorization, Dr., Physicians Diagnostic Services
- 03/24/10 Preauthorization Advisor Review Form, , LVN, xxxxx
- 03/18/10 EMG/NCV results, Physicians Diagnostic Services
- 03/18/10 Letter of Medical Necessity, Dr. , Physicians Diagnostic Services
- 02/16/10 Preauthorization Review Summary, xxxxxx

- 12/02/09 Notice from xxxxx, Executive Director, xxxxx
- 10/12/09 Subsequent Report, , D.C.
- 05/27/09 Operative Report, Dr., xxxxx
- 09/24/08 post myelogram CT cervical spine, MRI & Diagnostic
- 09/24/08 cervical myelogram, MRI & Diagnostic
- 08/08/08 Operative Report, , D.C., xxxxx
- 05/05/08 Subsequent Medical Report, Dr.
- 04/22/08 Operative Report, , M.D., xxxxx
- 11/27/07 MRI right shoulder, MRI & Diagnostic
- Undated Preauthorization Advisor Review Form, (with handwritten note)
- Undated Preauthorization Advisor Review Form, (with handwritten notes regarding contacts of 03/26/10 to 03/29/10)
- ODG Integrated Treatment/Disability Duration Guidelines for Pain (Chronic)
- ODG TWC Neck Guidelines – Electromyography and Nerve conduction studies
- American Association of Neuromuscular & Electrodiagnostic Medicine Recommended Policy for Electrodiagnostic Medicine, AANEM
- AANEM Guidelines for CPT Codes 95860 – 95870: Needle Electromyography
- AANEM Guidelines (CPT Codes 95900 – 95904: Nerve Conduction Studies)

PATIENT CLINICAL HISTORY [SUMMARY]:

Records indicate that the above captioned individual is a male who was allegedly involved in an occupational incident that reportedly occurred on xx/xx/xx. He presented to the office of the attending provider (AP) complaining of neck and right shoulder pain. An anterior cervical fusion of C4/5 was performed on 05/27/2009 and a SLAP lesion and rotator cuff repair on 04/22/2008. To date the injured individual has participated in a litany of care to include chiropractic management, medication management, steroid injections and manipulation under anesthesia (MUA) of the neck.

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

The injured individual underwent a previous electrodiagnostic study on 06/26/2007. The records reveal no recent clinical information that unequivocally demonstrates or suggests that the injured individual has a new trauma or exacerbation or that the injured individual is demonstrating or reporting increased or increasing neurologic deficits that would warrant a follow-up study. There is one entry that states that the injured individual's primary care physician (PCP) had noted that he had lingering neurologic deficits with progression. However, no report is submitted. The statement is anecdotal at best with no supporting documentation and no specific clinical findings are noted. Given the lack of documentation reflecting a recent change or deterioration in the condition or neurologic symptomatology, it is not clear what information would be gained from the study under review or how it might change or alter the course of care. As such, the medical necessity is not established.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Electromyogram (EMG):

Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). ([AAEM, 1999](#)) 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.

Positive diagnosis of radiculopathy: Requires the identification of neurogenic abnormalities in two or more muscles that share the same nerve root innervation but differ in their peripheral nerve supply.

Timing: Timing is important as nerve root compression will reflect as positive if active changes are occurring. Changes of denervation develop within the first to third week after compression (fibrillations and positive sharp waves develop first in the paraspinals at 7-10 days and in the limb muscles at 2-3 weeks), and reinnervation is found at about 3-6 months

Acute findings: Identification of fibrillation potentials in denervated muscles with normal motor unit action potentials (usually within 6 months of symptoms: may disappear within 6 weeks in the paraspinals and persist for up to 1-2 years in distal limbs).

Chronic findings: Findings of motor unit action potentials with increased duration and phases that represent reinnervation. With time these become broad, large and polyphasic and may persist for years.

Anatomy: The test primarily evaluates ventral (anterior) root function (motor) and may be negative if there is dorsal root compression (sensory) only. Only C4-8 and T1 in the neck region have limb representation that can be tested electrodiagnostically. The anatomic basis for this lies in the fact that the cervical nerve roots have a motor and a sensory component. It is possible to impinge the sensory component with a herniated disc or bone spur and not affect the motor component. As a result, the patient may report radicular pain that correlates to the MRI without having EMG evidence of motor loss.

Paraspinal fibrillation potentials: May be seen in normal individuals and are nonspecific for etiology. The presence of these alone is insufficient to make a diagnosis of radiculopathy and they may be absent when there is a diagnosis of radiculopathy secondary to sampling error, timing, or because they were spared. They may support a diagnosis of radiculopathy when corresponding abnormalities are present in the limb muscles.

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.

Nerve Conduction Study (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. ([Utah, 2006](#)) See also the [Carpal Tunnel Syndrome Chapter](#) for more details on NCS. Studies have not shown portable nerve conduction devices to be effective.