

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/25/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Bilateral upper extremity NCV/EMG

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Electrodiagnostic 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)

The reviewer finds that medical necessity exists for Bilateral upper extremity EMG. The reviewer finds that medical necessity does not exist for bilateral upper extremity NCV.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Neck Chapter, EMG

8/25/10, 9/2/10

M.D. 8/26/10

Spine and Rehab 4/27/10 to 8/24/10

Patient Notes 8/2/10, 6/25/10

M.D., P.A. 7/20/10

Imaging 7/13/10, 7/12/10, 2/10/06

Diagnostic 3/28/07

Physicians Stand-Up MRI 9/19/06

Radiology Associates 12/7/05

Pain Management Physicians 6/10/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a woman injured on xx/xx/xx. . She had boxes fall on her neck and shoulder. She underwent a cervical fusion (C4 to C6) in 2008 for central stenosis, and a shoulder surgery in 2003 and 2009. There are post op changes at C4-5-6 with a 3mm disc herniation at C3-4 and moderate foraminal narrowing at C4/5 in the (7/13/10) MRI. The shoulder MRI (7/12/10) showed partial supraspinatus tears. Dr. did not find any evidence of a radiculopathy. She

reportedly has ongoing neck pain and right upper extremity weakness. Dr wants to exclude a radiculopathy and brachioplexopathy with the studies. The “treating doctor” on 6/25/10 (signature not identified) reported normal sensation and right biceps and triceps reflex. He reported 2+ strength on the right side, but no specific region or group weakness. He noted she is depressed. Dr. did not describe a neurological exam, in the upper extremities. The 8/2/10 visit with a doctor felt there was some foraminal narrowing. There was no neurological exam provided. Dr. felt her symptoms were from an adhesive capsulitis, but wanted the EMG to see if there was nerve damage. Dr. noted 1+ triceps and biceps reflex and said there were “radicular symptoms.” None were described.

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

One note states she had some plexus finding in a 2006 EMG, but that was not provided. No one described a radicular pain pattern, but Dr. did comment that shoulder problems and C5 radiculopathy overlap. Depending upon the extent of surgery, there may be abnormalities from the surgery. The scars were not described in the report. The value of EMGs in documenting a radiculopathy are limited. The ODG suggests this in “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.” Her symptoms are the stiff shoulder and pain. The ODG notes “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.” I could not determine from the records if the symptoms are static or worsened. The foraminal narrowing apparently worsened since the fusion. Since these symptoms may have been progressive, then there is a role for the EMG to exclude a C5 radiculopathy. The C5 root would be in the C4/5 foramen and could refer shoulder pain. Therefore the EMG is medically necessary. The nerve conduction studies, including F responses, are not medically necessary based upon the ODG. The reviewer finds that medical necessity exists for Bilateral upper extremity EMG. The reviewer finds that medical necessity does not exist for bilateral upper extremity NCV.

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

- ACOEM-AMERICA 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)