

MAXIMUS Federal Services, Inc.
11000 Olson Drive, Suite 200
Rancho Cordova, CA 95670
Tel: [800] 470-4075 ♦ Fax: [916] 364-8134

Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 16, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV studies of the bilateral upper extremities.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overtured (Disagree)**
- Partially Overtured (Agree in part/Disagree in part)

EMG/NCV studies of the bilateral upper extremities are medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 10/25/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/27/10.
3. Notice of Assignment of IRO dated 10/27/10.
4. Notice to Utilization Review Agent of Assignment of IRO dated 10/27/10.
5. Medical records from MD dated 10/5/09, 10/6/09, 3/24/10, 4/13/10, 5/25/10 and 9/28/10.
6. Reauthorization request from MD dated 10/11/10.
7. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an on-the-job injury on xx/xx/xx. The patient underwent cervical spine surgery in July 2008 at multiple levels. When she failed to have her pain resolve she was evaluated and it was determined that she would need to undergo a repeat cervical spine procedure from C3 to C7. This procedure occurred in March 2010. The patient sought authorization for physical therapy two times per week for four weeks. The patient was subsequently diagnosed with failed cervical spine syndrome post reconstruction. On 9/28/10, the patient's chief complaint was noted to be left trapezius and shoulder pain. The patient was diagnosed with impingement syndrome left shoulder and rule out chronic radicular symptoms from previous surgery. Her provider has recommended EMG/NCV of the bilateral upper extremities for determination of active and ongoing radiculopathy and to distinguish this from the local shoulder pain. The Carrier has denied this request indicating that the proposed service is not medically necessary for treatment of the patient's shoulder pain.

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

The Official Disability Guidelines (ODG) under "Discectomy-laminectomy and laminoplasty indication for surgery" list the need for EMG as "optional and not required." The ODG further state, "EMG is useful when clinical findings are complex or unclear, there is a discrepancy in imaging or to identify other etiologies of symptoms such as metabolic (diabetes, thyroid disease) or peripheral pathology (carpal tunnel)." In order to meet the recommendations of the use of EMG to detect any of the above etiologies or symptoms, both EMG and NCS need to be performed, which is consistent with the provider's request in this case. The ODG recommend that the electrodiagnostic testing be done prior to cervical spine surgery. According to the medical records, the patient did not have electrodiagnostic testing prior to surgery. However, the issues that EMG/NCS testing would have ruled out still remain. The patient is not only post cervical fusion once, but now twice. Most of the medical guidelines including the ODG do not address cases that are this complex. In a case such as this, it is necessary to look beyond the

impressions of “shoulder impingement syndrome” and “cervical radiculopathy” and to consider the overall complexity of this patient’s condition. Given the complexity of this case, EMG/NCV is within the standard of care and is medically necessary.

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)