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**Notice of Independent Review Decision
Reviewer's Report**

DATE OF REVIEW: August 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The patient has requested coverage for Electromyography (EMG) and Nerve Conduction Velocity (NCV) testing of the left upper extremity.

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)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

I have determined that the requested EMG and NCV testing of the left upper extremity is not 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 8/5/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Medical Review Organization (IRO) dated 8/5/10.
3. TDI Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 8/6/10.
4. TDI Notice to IRO of Case Assignment dated 8/6/10.
5. Letter of Medical Necessity from DC dated 7/1/10.
6. Initial Orthopaedic Consultation from, MD dated 6/23/10.
7. Treatment records from Chiropractic Center dated 6/17/09 through 4/1/10.
8. MRI of left elbow dated 6/18/09.
9. Evaluation from, MD dated 6/25/09 and Follow-up Evaluation dated 2/11/10.
10. Rehabilitation records dated 7/13/09 through 8/5/09.
11. Progress Note from MD dated 3/5/10 and 3/16/10.
12. MRI of left elbow dated 3/16/10.
13. Denial documentation.
14. ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on the job on xx/xx/xx while working as a. Specifically, the patient reports that while disconnecting a pipe from his tanker trailer, another pipe fell and struck him on the lateral aspect of the left elbow and then pinned his left elbow between the pipe and another metal duct. An MRI was performed on 6/18/09 and revealed a small to moderate sized joint effusion. The olecranon also showed moderate inflammatory change consistent with olecranon bursitis and

degenerative changes throughout the elbow. The records indicate the patient was referred for Electromyography/Nerve Conduction Velocity (EMG/NCV) testing which revealed no significant abnormalities. The patient continues to have pain. On 6/23/10, the patient was evaluated by an orthopedist who recommended a repeat EMG/NCV study. According to one of the patient's provider's, the patient exhibits clinical indications of medial and lateral epicondylitis and continues to be symptomatic. The patient was noted to have "decreased two point discrimination in the left ulnar distribution." Therefore, the provider indicates that the requested service is medically necessary to rule out or confirm neuropathy and determine a precise prognosis and optimal treatment plan for the patient. The patient is seeking coverage for repeat EMG/NCV testing at this time.

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

Electromyographic nerve conduction (EMG/NCV) tests are diagnostic studies designed to evaluate the function of large myelinated nerve fibers, i.e., the motor nerves. Thus, they do not evaluate the function of smaller myelinated and unmyelinated sensory nerves, which may show pathologic changes before the involvement of the motor nerves. The Official Disability Guidelines do not address re-testing of EMG/NCV in elbow trauma. The submitted documentation indicates that the patient's original EMG/NCV testing showed no abnormality. There are no new objective physical findings or change in symptoms to suggest progression of disease. There is no history of other co-incident neurologic disease. As such, there is no evidence that repeat EMG/NCV testing is likely to result in clinically useful information that will affect the care and management of this patient. Accordingly, I have determined that the requested service is not medically necessary for treatment of the patient's medical condition.

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)