

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 21, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV on Left Upper Extremity

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

This reviewer is licensed by Texas Board of Chiropractic Examiners with 14 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On June 14, 2010, the claimant was evaluated by DC, a chiropractor. Impression: 1. Synovitis of elbow. 2. Pain in elbow joint. 3. Lateral epicondylitis.

On June 24, 2010, the claimant participated in a physical performance test.

On July 6, 2010, an MRI of the left elbow was performed. Impression: 1. Mild thickening of the common extensor tendon attachment suggest mild degree of epicondylitis may remain. Overall the signal intensity of the tendon attachment as well as the overlying soft tissues is reduced compared to prior scan. 2. Accessory ossicle probably unfused growth plate at the medial epicondyle at the medial ulnar collateral ligament attachment. 3. No acute fracture or destructive bone lesion. 4. Minimal joint fluid as interpreted by M.D.

On July 16, 2010, D.C., a chiropractor. performed a utilization review on the claimant. Rational for Denial: The records supplied do not demonstrate that the patient has completed the trial of physical therapy and as a result the request for an EMG/NCV is not supported as necessary pending the results of the trial of PT that has been certified. Therefore, it is not certified.

On July 22, 2010, the claimant was re-evaluated by DC. The claimant had complaints of left epicondylitis with radicular symptoms down the left side of the left arm. The claimant has completed 6 sessions of physical therapy with good response to endurance and increase in ROM, with continued pain at the origin of the brachioradialis muscle with radicular symptoms on certain movements.

On July 28, 2010, D.C., a chiropractor. performed a utilization review on the claimant. Rational for Denial: THE OSG TWC 2010 Forearm, elbow and wrist chapter only

recommends EMG/NCV “after closed fractures of distal radius and ulnar is necessary to assess nerve injury”. In this case there is no history of such fractures. The ODG also states an EMG/NCV is recommended for patients who are candidates for surgery, the claimant is not a surgical candidate. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant sustained a sprain injury to the left elbow. She continues to experience functional limitations performing daily activities, resulting from increased symptomology of current complaints.

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

It is recommended per the ODG Guidelines that an EMG / NCV study to be utilized when the claimant has a closed fracture of the distal radius and ulna; utilized to assess nerve injury (post fracture). On July 22, 2010, Dr. noted that the claimant completed six sessions of physical therapy with good results and functional improvement was noted in the increase of range of motion. Pain was noted during certain movements. This claimant is not a surgical case therefore an EMG / NCV is not medically necessary per the ODG guidelines. The previous decisions are upheld.

ODG Guidelines:

Recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. (Bienek, 2006) Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), and possibly the addition of electromyography (EMG). For more information, see the Carpal Tunnel Syndrome chapter.

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 KNOWLEDGBASE
- 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)