

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/03/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Out-patient (OP) Electromyography and Nerve Conduction study

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

M.D., Board Certified Neurologist

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Utilization review 09/01/11

Determination letter 09/02/11

Utilization review 09/27/11

Determination letter 09/27/11

Report of medical evaluation (doctor selected by treating doctor) 05/04/11

Operative report right shoulder arthroscopy with rotator cuff repair, debridement, synovectomy, acromioplasty and distal clavicle resection 05/21/10

Office notes D.O. 08/16/11 and 09/15/11

Upright MRI cervical spine 08/22/11

Designated doctor evaluation M.D. 12/21/10

Initial medical report D.C. 10/15/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who was injured on xx/xx/xx while working as for. She tripped and fell face forward and struck her right shoulder on ground. Records indicate the claimant sustained a right proximal humerus fracture with extension into greater tuberosity of displaced fragment. The claimant underwent right shoulder surgery on 05/21/10 for diagnosis of rotator cuff tear with labral tear and impingement syndrome followed by postoperative physical therapy. The claimant has had ongoing neck pain and bilateral arm pain. Examination on 08/16/11 reported cranial nerves II-XII intact; motor 5/5 throughout. Sensation was intact to all modalities. Gait was normal. There was no clonus and toes were downgoing. MRI cervical spine performed on 08/22/11 revealed disc protrusion at C2-3, C3-4, C4-5, C5-6 and C6-7. The claimant was recommended to undergo EMG to rule out cervical radiculopathy.

A preauthorization request for EMG/NCV was reviewed on 09/01/11 and determined not to be medically necessary. It was noted the history and documentation do not objectively support the request for EMG/NCV at this time. The claimant was found to have reached MMI but returned with neck and upper extremity pain. There is no evidence she has completed all reasonable conservative treatment for current complaints. Fibromyalgia is possible diagnosis, and there are no focal neurologic deficits that warrant proceeding with electrodiagnostic studies at this time. There are no findings of possible radiculopathy or peripheral nerve compression. An appeal request for EMG/NCV was reviewed on 09/27/11, and the request was determined to not be medically necessary. It was noted there were no objective findings to support acute nerve root compression. Therefore, EMG/NCV is not medically necessary. There is fibromyalgia, and appropriate specialist should assess the claimant.

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

The clinical data provided for review does not support determination of medical necessity for the proposed Out-patient (OP) Electromyography and Nerve Conduction study. The claimant is noted to have sustained an injury when she fell on xx/xx/xx injuring her right upper extremity and shoulder. The patient underwent right shoulder arthroscopic surgery on 05/21/10. She subsequently complained of neck and arm pain. Examination performed on 08/16/11 revealed no motor or sensory changes. Reflexes were 1+ throughout. MRI of cervical spine was obtained and showed multilevel disc protrusions without focal disc herniation or nerve root compression identified. Noting there are no evidence of neurocompressive pathology on MRI, and no deficits on neurologic examination indicative of radiculopathy, the reviewer finds the proposed Out-patient (OP) Electromyography and Nerve Conduction study is not medically necessary.

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 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)