



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

07/07/2011

DATE OF REVIEW: 07/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Electromyography/Nerve Conduction Velocity (EMG/NCV) of the Right Upper Extremity

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

Texas State Licensed MD Board Certified Occupational Medicine physician

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

1. Texas Dept of Insurance Assignment to Medwork 06/20/2011
2. Notice of assignment to URA 06/20/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 06/17/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 06/03/2011
6. Utilization Review Unit 05/11/2011, Medicals 05/10/2011, UR Unit 05/05/2011, 05/03/2011, Medicals 05/03/2011, 04/22/2011, 04/15/2011, 04/12/2011, 04/11/2011, 03/28/2011, TDI form 06/21/2010.
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

This is a man who developed chronic right shoulder pain while lifting a heavy object at work on xx/xx/xx. The patient was diagnosed with the shoulder strain. He was prescribed pain medication and was released to full duty. The patient's symptoms were not resolved, however.



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He presented with complaint of severe persistent pain and stiffness in his right shoulder with occasional numbness and tingling in his hand. He also reported inability to do daily chores of life, such as bathing and dressing, due to limitations of the joint movement. On examination, he was noted to have restricted range of motion (abduction: 145°, flexion: 90° and extension: 35°) with evidence of rotator cuff tear and impingement. The patient was prescribed physical therapy and modified duty. He was also recommended to undergo MRI imaging and EMG/NCV studies of the right upper limb for further assessment. On his last follow-up, the patient reported moderate to severe pain in his shoulder with locking of the joint in certain positions. On examination, he was again noted to have restriction of range of motion, decreased muscle strength and signs of rotator cuff pathology. Additionally, he was also noted to have decreased sensation in the C6 nerve distribution of the extremity. The patient was advised to continue with conservative management of his condition, pending further diagnostic evaluation. Review request is for Electromyography/Nerve Conduction Velocity (EMG/NCV) of the Right Upper Extremity.

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

The Official Disability Guidelines state: "EMGs (electromyography) is recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%)". As per ODG Guidelines: "Nerve conduction studies (NCS) are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy". Based on ODG recommendations and the records reviewed, there is no indication for the requested Electromyography/Nerve Conduction Velocity (EMG/NCV) of the Right Upper Extremity studies in this patient; therefore, the insurer's denial is upheld due to the following considerations:

- This patient developed pain in his right shoulder as a result of lifting heavy objects at work. On examination, he had tenderness of the posterior shoulder and restriction of range of motion of the joint, especially abduction; drop arm test and subscapularis lift off test for possible rotator cuff tear were also positive.
- Although on his follow-up, the patient reported radiation of his shoulder pain to the neck, there was no restriction of range of motion of his cervical spine (FCE report dated 4/12/11, page. 06) or evidence of overt radiculopathy on his physical findings.
- Cervical spine and rotator cuff pathology may present in very similar clinical patterns, including pain in the neck, shoulder, scapula, arm and hand. However, rotator cuff pathology is most commonly caused by external causes, such as a traumatic tear in the tendon from a fall or accident or from repetitive lifting, pushing or pulling. Cervical radiculopathy is usually the result of disc herniation or cervical spondylosis.

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



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- 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)