

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: July 18, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient EMG/NCV of the bilateral upper extremities (BLE).

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

This physician is a Board Certified Physical Medicine and Rehabilitation with over 15 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

January 4, 2007: MRI Cervical Spine (read by:, MD) **Findings:** There is straightening of the mid to upper cervical lordosis with no spodylostisthesis. The bone marrow is unremarkable. At both the C4-C5 and C5-C6 level, there is

broad posterior central 1-2 mm disc protrusion pressing on the anterior thecal sac. Remaining cervical levels demonstrate no disc bulge or herniation. No neural foraminal narrowing is seen at any cervical level. The cervical spinal cord is unremarkable. No additional findings are seen.

November 20, 2007: Designated Doctor Report completed by, MD certifying that Ms. reached statutory MMI as of 6/03/2006 and has a permanent impairment of 41%.

July 22, 2008: Operative Report (by, MD) **Preoperative diagnosis:** Left upper extremity complex regional pain syndrome **Procedure:** Placement of trial cervical spinal cord stimulator—2 leads, fluoroscopic guidance/needle localization and program generator. **Postoperative diagnosis:** Left upper extremity complex regional pain syndrome

July 29, 2008: Ms. was examined by Dr. who performed a follow-up examination after the 7/22/08 surgery. He removed the spinal cord stimulator.

August 26, 2008: Ms. was examined by Dr., DO in place of Dr.. He prescribed her Zanaflex, Skelaxin, Duragesic patch and Gabapentin. He recommended her to take all medications as prescribed.

September 30, 2008: Ms. was examined by Dr., DO in place of Dr.. He prescribed her Zanaflex, Skelaxin, Duragesic patch and Gabapentin. He recommended her to take all medications as prescribed.

November 18, 2008: Ms. was examined by Dr., DO in place of Dr.. He prescribed her Zanaflex, Skelaxin, Duragesic patch and Gabapentin. He recommended her to take all medications as prescribed. He also gave her a DVD on intrathecal narcotic pump.

December 4, 2008: Ms. was examined by Dr., PA in place of Dr.. He prescribed her Zanaflex, Skelaxin, Duragesic patch and Gabapentin. He recommended her to take all medications as prescribed. Ms. considered the intrathecal narcotic pump.

January 8, 2009: Ms. was examined by Dr., DO in place of Dr.. He prescribed her Zanaflex, Skelaxin, Duragesic patch and Gabapentin. He recommended her to take all medications as prescribed. Ms. considered the intrathecal narcotic pump.

February 10, 2009: Ms. was examined by Dr., DO in place of Dr.. He prescribed her Zanaflex, Skelaxin, Duragesic patch and Gabapentin. He recommended her to take all medications as prescribed. Ms. was instructed to review the intrathecal narcotic pump for consideration.

March 12, 2009: Ms. was examined by Dr., PA in place of Dr.. He prescribed her Zanaflex, Skelaxin, Duragesic patch and Gabapentin. He recommended her to take all medications as prescribed.

April 23, 2009: Ms. was examined by Dr.. He prescribed her Zanaflex, Neurontin, and Norco. He recommended her to take all medications as prescribed. He also scheduled her for chronic pain management program. **FCE Exam:** Ms. was required to lift a 30 by 30 centimeter crate weighing 10 pounds from the floor to waist level with progressively increased loads. She was monitored with respect to her rate (physiological), lifting mechanics (biomechanical) and perceived exertion (psychophysical) Ms. attempted by was unable to safely and dependably perform due to complaints of severe pain of the compensable injury areas that are noted. This test and dynamic floor to shoulder and carrying test was terminated for safety precautions.

May 19, 2009: CMT/ROM: ROM findings: Cervical- Flexion- 34% of the norm; Extension- 52% of norm; Left Lateral- 67% of norm; Right lateral 64% of norm. **Upper Extremity:** Elbow Flexion- 105 of norm. Ms. was examined by Dr. He recommended her to take all medications as prescribed and schedule her for chronic pain management program.

June 16, 2009: Ms. was examined by Dr.. He recommended her to take all medications as prescribed and schedule her for further evaluation of the left upper extremity.

July 16, 2009: Ms. was examined by PA-C who recommended her to take all medications as prescribed. He also prescribed an MRI of her elbow to insure that she is not experiencing any postoperative complications. He also wanted to obtain an EMG/nerve conduction study to evaluate her neuropathic pain.

July 23, 2009: Ms. was examined by Dr., MD who recommended that she undergo a repeat EMG of the left upper extremity prior to any scar revision to see if the deeper structures will require another release.

August 13, 2009: Ms. was examined by, PA-C who recommended her to take all medications as prescribed.

September 24, 2009: Ms. was examined by, MD who sent Ms. to the chronic pain management program and recommended her to continue to take all medications as prescribed.

October 22, 2009: Ms. was examined by who recommended her to check on the status of the pain management program and take all medications as prescribed.

December 1, 2009: CMT/ROM: ROM findings: Cervical- Flexion- 54% of the norm; Extension- 52% of norm; Left Lateral- 64% of norm; Right lateral 60% of norm. Left Rotation- 100% of norm; Right Rotation- 100% of norm. Ms. was examined by who recommended her to take all medications as prescribed.

January 5, 2010: MMT/ROM: ROM findings: Cervical- Flexion- 68% of the norm; Extension- 77% of norm; Left Lateral- 64% of norm; Right lateral 71% of norm. Left Rotation- 100% of norm; Right Rotation- 100% of norm. Ms. was examined by who recommended her to take all medications as prescribed and to continue with medication maintenance.

March 8, 2010: Ms. was examined by who recommended her to take all medications as prescribed, to follow up with her primary care physician concerning elevated blood pressure, and to continue with medication maintenance. Ms. tested negative for all narcotic abuse.

June 7, 2010: Ms. was examined by who recommended her to take all medications as prescribed and to continue with medication maintenance.

August 17, 2010: Ms. was examined by Dr. who recommended her to take all medications as prescribed, and scheduled her for evaluation of her left elbow, orthopedics.

September 16, 2010: MMT/ROM: ROM findings: Cervical- Flexion- 68% of the norm; Extension- 75% of norm; Left Lateral- 84% of norm; Right lateral 89% of norm. Left Rotation- 88% of norm; Right Rotation- 88% of norm. Ms. was examined by, PA- C, who recommended her to take all medications as prescribed and scheduled her for evaluation of her left elbow, orthopedics.

November 15, 2010: Ms. was examined by Dr. who recommended her to take all medications as prescribed, and scheduled her for evaluation of her left elbow, orthopedics.

January 17, 2011: Ms. was examined by PA- C, who recommended her to take all medications as prescribed and scheduled her for evaluation of her left elbow, orthopedics.

April 26, 2011: Ms. was examined by Dr. MD who recommended an EMG bilateral upper extremities and to follow up with Dr. for pain management recommendations.

May 19, 2011: Ms. was examined by PA- C, who recommended her to take all medications as prescribed and obtain upper extremity EMG.

June 9, 2011: M.D. performed an UR on the claimant. Rationale of Denial: It is not clear that there has been progression of neurologic signs since the last study.

June 21, 2011: M.D. performed an UR on the claimant. Rationale of Denial: There is no clinical evidence of radiculopathy and no change in clinical status.

PATIENT CLINICAL HISTORY:

This correctional officer was injured on the job on xx/xx/xx. He complained of neck, thoracic spine, and left upper extremity pain.

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

The previous decisions are upheld. There is a lack of clinical information regarding neurologic signs and symptoms; therefore, the EMG/NCV of bilateral upper extremities is denied.

Per the ODG:

Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:

- (1) EDX testing should be medically indicated.
- (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for “screening purposes” rather than diagnosis are not acceptable.
- (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.
- (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.
- (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.
- (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.
- (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. ([AANEM, 2009](#))

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)