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Notice of Independent Review Decision

DATE OF REVIEW: MAY 17, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed EMG/NCV RLE 95860

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
719.46	95860		Prosp	1					Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the first non-certification for this request. It is noted that the pain complaints are associated with range of motion activities. There was no objective suggestion of a need for an electrodiagnostic study.

The narrative peer review included a thorough history dating back to. There was a fall, a "pop" in the knee and a "burning sensation." There was a positive McMurray's sign and plain radiographs noted a moderate osteoarthritis. A Designated Doctor evaluation suggested an electrodiagnostic assessment to rule out a verifiable radiculopathy. The need for EMG was ruled out as the clinical reason for the pain complaints has been established.

In December, there was a third change in treating doctors. The initial assessment for that provider noted the decreased range of motion of the knee and the chondromalacia patella on MRI. The injured employee sought re-

consideration for this request based on the suggestion of the Designated Doctor and not based on the evidence based medicine cited. The Designated Doctor physical examination noted no swelling or effusion, no medial joint line tenderness, there was some lateral joint line tenderness, the knee was stable to ligamentous stress. Muscle strength was reported as 5/5 on the left and 2/5 on the right with a "poor effort." No atrophy was reported. The diagnosis offered by the Designated Doctor was contusion, bursitis and chondromalacia patella. Irrespective of the physical examination that he reported, the Designated Doctor felt that there might be a neuropathy and that this required electrodiagnostic assessment. The Designated Doctor is noted to be a Family Practice Provider and not an orthopedist or neurologist.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION, IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines knee chapter (Updated April 28, 2011) there is no discussion for an EMG in a knee injury. In that the Designated Doctor suggests the possibility of a peripheral neuropathy, I visited the lumbar chapter and noted this for EMGs

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](#))

The first point to make is that the physical examination of the Designated Doctor offers no clinical indication for this study. A subjective complaint of sensory loss, in the face of this particular mechanism of injury makes no clinical sense. There is no discretion as to the need for nerve conduction studies versus myographic assessment. With the physical examination noting 2/5 muscle on poor effort and 5/5 on the contralateral uninvolved side, again there is no objective parameter noted to seek this study. In short, there simply is no competent, objective and confirmable medical evidence or evidence based medicine to support this request from a clinical basis. There are pain complaints; however, one has to consider the mechanism of injury, the lack of any physical examination findings and the objective data prior to seeking an invasive study.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES