

SENT VIA EMAIL OR FAX ON
Apr/21/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCS Bil UE

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

Board Certified Orthopedic Surgeon

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

OD Guidelines

1. Office visit notes MD 05/05/10 through 03/09/11
2. Insurance Company's response regarding disputed services 04/11/11
3. Utilization review determination 02/22/11 regarding non-certification EMG/NCS bilateral upper extremities
4. Utilization review determination non-certification reconsideration/appeal request EMG/NCS bilateral upper extremities
5. Required medical examination MD 11/30/10
6. Operative note 03/29/10 regarding C3-4 laminectomy and bilateral foraminotomies, C6-7 bilateral foraminotomies, C2 to T2 posterior fusion with instrumentation
7. MRI cervical spine 11/05/09
8. X-rays cervical spine 02/16/11 and 07/07/10
9. Progress notes MD

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a female whose date of injury is xx/xx/xx. Records indicate that she was lifting heavy boxes of files and had onset of neck pain. After a course of conservative management, the injured employee underwent anterior cervical discectomy and fusion C4-7 on 07/21/06. On 03/16/09 the injured employee underwent removal of fixation plate and repair of non-union at C6-7. On 03/29/10 the injured employee underwent laminectomy with bilateral foraminotomies at C3-4 and bilateral foraminotomies at C6-7 with posterior fusion with instrumentation C2 through T2. Following this last surgery the injured employee complained of escalating neck pain. The injured employee also complained of increasing weakness in the left hand and escalating leg pain. Office note dated 02/09/11 indicates the injured employee had CT scan of the neck by Dr. but the report was not available. The injured employee was recommended to have EMG/NCV studies.

A utilization review was performed by Dr. on 02/22/11 and the request for EMG/NCS of the bilateral upper extremities was determined to be non-certified. Dr. noted that per medical report dated 12/15/10 the injured employee complains of neck pain. On physical examination the cervical spine shows significant limitation of range of motion in all directions. There is significant paraspinous and shoulder girdle muscle spasm. Dr. noted the operative report of the previous cervical surgery was not submitted for review and appraisal. There is no clear documentation of conservative treatment including physical therapy and

activity modification. Also optimized pharmacotherapeutic utilization in conjunction with VAS scoring and rehabilitative support was not evident in the report. Accordingly Dr. determined the request was non-certified.

A reconsideration request was reviewed by Dr. on 03/02/11, and the appeal request for EMG/NCS bilateral upper extremities was determined as non-certified. Dr. noted the injured employee underwent 3 cervical spine surgeries including C3-4 laminectomy and bilateral foraminotomies, C6-7 bilateral foraminotomies, and C2-T2 posterior fusion with instrumentation on 03/29/10. The requested electrodiagnostic study was recommended in the medical report dated 12/15/10 to verify the presence of C7 radiculopathy. Physical examination at this time revealed significant cervical spine range of motion limitations, decreased sensation along the left C7 dermatome, normal bilateral grip strength, decreased left C7 reflex, and probably minimally decreased left elbow extensors. Dr. noted the aforementioned report did not document testing for Spurling's sign to corroborate the suspected cervical radiculopathy. Medical report dated 02/23/11 did not document findings that support suspected cervical radiculopathy. It was noted there is no objective evidence the injured employee has maximized benefits from conservative treatment including pharmacotherapy, activity modifications, and physical therapy. There was no clearly expressed need for proposed electrodiagnostic study and evaluating potential spinal interventions including injections or surgery. Dr. further noted that with regard to reference guidelines there was minimal justification for performing nerve conduction studies when the injured employee is presumed to have symptoms on basis of radiculopathy. As such, it was determined the requested bilateral upper extremity EMG/NCS was not fully substantiated, and previous non-certification was upheld.

The injured employee was seen in follow-up on 03/09/11. Dr. noted the injured employee is being treated for severe neck pain. The injured employee was noted to be complaining of fairly severe neck pain which is mostly axial, but she does get some radiation into both shoulders but worse on right than left. The axial pain, however, is the most significant of all the pain. The peripheral radiation is not bothering the injured employee too much. Examination of the cervical spine at this time showed relatively good range of motion in all planes. Spurling's test was negative. Facetal step off maneuvers were negative. There were no Waddell's signs. Neurologic examination of upper extremities was within normal limits.

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

Based on the clinical information provided, the request for EMG/NCS of bilateral upper extremities is not seen as medically necessary. The injured employee is noted to have sustained an injury in xxxx. She has undergone multiple surgeries including ACDF C4-7 and posterior fusion C2-T2. The injured employee continues to complain of neck pain. On most recent examination the injured employee had relatively good motion of the cervical spine in all planes. Spurling's test was negative. Neurological examination of the upper extremities was within normal limits. Noting there is no evidence of motor, sensory or reflex changes to the upper extremities, and noting that the injured employee complains of axial pain without significant peripheral radiation, there is no medical necessity for electrodiagnostic testing.

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 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)