

Applied Resolutions LLC

An Independent Review Organization
900 N. Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Phone: (214) 329-9005
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies of bilateral upper extremities

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

Board Certified PM&R; Board Certified Pain 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

Initial visit and progress notes 01/09/12-04/18/12

MRI cervical spine without contrast dated 01/18/12

Procedure note cervical epidural steroid injection dated 02/01/12

Clinic note M.D. 03/27/12

Notice of denial of preauthorization dated 04/04/12

Letter of medical necessity EMG/NCV dated 05/20/12

Notice of denial of preauthorization dated 05/31/12

Request for reconsideration dated 06/06/12

Notification of determination dated 06/08/12

Notice of reconsideration dated 06/12/12

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant is a male whose date of injury is xx/xx/xx. Records indicate he was working with a construction crew when he was struck from behind by a bulldozer. He subsequently complained of pain radiating from the base of the neck all the way down the right arm. The claimant is noted to have a history of prior C6-T1 anterior cervical fusion. MRI of the cervical spine dated 01/18/12 revealed prior anterior fusion at C6-7 and C7-T1. The fusion appears solid. There is multilevel degenerative disc disease with at least moderate central canal narrowing at C3-4 with cord flattening. There is bilateral neural foraminal stenosis at this level. At C4-5 there is mild central canal narrowing and bilateral foraminal narrowing. At C5-6 there is mild central canal narrowing with bilateral neural foraminal narrowing. It was noted that there was thinning of the spinal cord at the C6-7 level with signal changes suggesting myelomalacia, likely related to an old insult. Records indicate the claimant was treated conservatively with medications, therapy, and cervical epidural steroid injection.

Per letter of medical necessity dated 05/20/12 the claimant was recommended to undergo updated electrodiagnostic studies of the bilateral upper extremities to evaluate etiology of continued pain presentation in neurologic demise.

The request for EMG/NCV studies of the bilateral upper extremities was denied by utilization review on 05/23/12 noting that the requests for electrodiagnostic studies of the bilateral upper extremities were not warranted as there were no findings in left upper extremity. The claimant was having only right upper extremity pain and symptoms. Therefore bilateral electrodiagnostic studies and nerve conduction test does not appear to be medically indicated. The claimant is noted to have some decreased sensation deficits in the C6 distribution on the right and typically treatment guidelines do not support electrodiagnostic studies if radiculopathy is obvious on physical examination findings. The main reason for non-certification at this time is that the treating provider is requesting bilateral upper extremities be tested and there are no physical examination findings on the left side to warrant the need for bilateral electrodiagnostic studies.

A reconsideration request for electromyography (EMG) and nerve conduction velocity (NCV) studies of the bilateral upper extremities was denied on utilization review dated 06/08/12. It was noted on evaluation dated 06/06/12 there were subjective complaints of neck and right arm pain. There is decreased active range of motion. Active range of motion was limited in all planes. Compression testing was provocative for central pain and right upper extremity pain. There is point tenderness noted over mid cervical facet regions with reflective spasms. Dermatomal reflective zones and myotome deficits were noted in C6 distribution on right. Reviewer noted previous Non-certification dated 05/24/12 was because there were no findings in left upper extremity to warrant bilateral study. It was noted the additional medical records included and evaluation on 06/06/12. There does not appear to be any additional information provided by treating provider that results in recommendation for certification. The claimant is only having symptoms on right side. The guidelines will not support bilateral upper extremity EMG/NCV and there are no symptoms on left side. There is minimal justification for performing nerve conduction studies when individual is presumed to have symptoms on basis of radiculopathy. As such, the request is not medically supported.

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

Based on the clinical information provided, medical necessity is not supported for electromyography (EMG) and nerve conduction velocity (NCV) studies of bilateral upper extremities. The claimant sustained an injury on 10/21/11. He complains of pain radiating from base of neck down the right arm. He has remote history of previous C6-7, C7-T1 anterior fusion. Records indicate the claimant has no left sided complaints or symptoms. He has been treated with therapy, medications, and epidural steroid injection. It appears that right sided radiculopathy in C6 distribution is clinically obvious and electrodiagnostic testing is not supported as medically necessary. As such, previous denials are upheld on IRO.

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)