

US Decisions Inc.

An Independent Review Organization
9600 Great Hills Trail Ste 150 W
Austin, TX 78759
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat EMG of the bilateral upper extremities and repeat NCV of the bilateral upper extremities

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

M.D., 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

Official Disability Guidelines and Treatment Guidelines
Request for IRO 12/20/11
Utilization review determination 11/21/11
Utilization review determination 12/06/11
Clinical records Dr. 09/08/11
Peer review Dr. 01/09/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained an injury to the head on xx/xx/xx. He stood up and struck the left side of his head and began complaining of neck and left shoulder and left leg pain. The claimant was evaluated on 01/13/11 and diagnosed with a brief loss of consciousness and cervicgia and cervical strain and contusion to the shoulder and knee. He was referred for CT of the head, which was reported as normal. He is noted to have undergone extensive physical therapy. He was referred for MRI on 03/08/11, which included the left knee and left ankle and left shoulder. The MRI of the shoulder showed a full thickness tear of the anterior distal rotator cuff with partial retraction of the supraspinatus and tears of the glenoid labrum and vertical changes along the head of the biceps tendon. Radiographs of the knee showed shredding and extrusion of the medial meniscus with medial joint space loss and moderate medial compartment osteoarthritic changes. MRI of the left ankle was reported to have shown tears of the anterior talofibular ligament and deltoid ligament and fibulocalcaneal ligament of undetermined chronicity and tears of the flexor hallucis longus and peroneal tendons. The claimant was recommended to undergo surgery for both his shoulder and knee. Left knee surgery was performed on 07/06/11. MRI of the cervical spine was performed on 07/12/11 which notes moderate degenerative changes and facet hypertrophy at C3-4 and C4-5 with a broad based disc protrusion of 4mm at the C4-5

level. Claimant underwent surgery for shoulder on 08/03/11. On 09/08/11 Dr. saw the claimant. The claimant was reported to have had an eight-month history of cervical pain and he reports raising his head and hitting an overhang. The claimant was noted to have undergone left knee surgery and left shoulder surgery and right shoulder arthroscopic surgery on and exploratory kidney surgery in 1981 and left hand surgery in 1991. He has a history of motor vehicle accident resulting in a sternal fracture of right pneumothorax and left mini-patellar fracture and right jaw fracture and nose fracture and bilateral inguinal herniorrhaphies in 1973. He is 72" tall and weighs 203 pounds. He is tender over the entire cervical spine as well as bilateral cervical spine. Range of motion testing shows flexion at 100% resulting in posterior neck pain. Extension is normal but elicits posterior neck pain. Deep tendon reflexes are normal in the bilateral upper extremities and motor strength is intact and there is no documentation of sensory loss. Radiographs are reported to suggest narrowing of the C1-2 and questionable compression fractures.

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

This man has a chronic history of cervical pain associated with work place event. He previously had EMG/NCV studies of bilateral upper extremities, but these studies were not included for this review. In a physical examination performed on 09/08/11 he shows no objective evidence of radicular symptoms. Motor strength and reflexes are intact, and there is no documented sensory testing. In the absence of objective findings that would indicate nerve root compromise, the reviewer finds the requested Repeat EMG of the bilateral upper extremities and repeat NCV of the bilateral upper extremities is not medically necessary. It is not supported under Official Disability Guidelines.

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)