



# INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision  
**AMENDED REPORT**  
 Information omitted from "Information Provided for Review" section.  
 See bold print.

**DATE OF REVIEW:** 02/06/12

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

EMG/NCS study, bilateral upper extremity

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified in Neurology with Added Qualifications in Pain Management, fellowship trained in Pain Medicine

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. Certification of independence of the reviewer
2. TDI case assignment
3. Letter of denial, 12/29/11 and 12/09/11, including criteria used
4. Treating doctor's evaluations dated 10/04/11, 11/18/11, and 01/10/12
5. Physical therapy progress notes for the period of 10/06/11 through 10/28/11
6. MRI scan of left shoulder without contrast on 09/11/11.
- 7. Correspondence from Texas Mutual 01/19/12.**
- 8. Records review report 10/31/11.**
- 9. Office visit notes from family practice treating doctor 08/19/11 – 12/19/11.**

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
<b>840.4</b>			<b>Prosp.</b>						<b>Overturn</b>

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This claimant sustained a work-related injury on xx/xx/xx. Available records indicate that the claimant has had symptoms in the left shoulder and arm, including pain and paraesthesias, as well as weakness in multiple muscle groups. One of the prior reviewers, who denied the requested study, does summarize the medical records as showing the claimant to have complaints of shoulder pain, as well as weakness of motor strength, including multiple muscle groups that are outside of just one myotome or nerve root level and, therefore, would not be adequately explained by a simple, single-level, radicular process.

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

The multiple myotomes demonstrated on exam, combined with shoulder pain complaints, do bring the possibility of a brachial plexopathy into the picture, and this could be further clarified by the requested electrical study. Therefore, I believe the EMG/NCS study requested for the upper extremity is medically reasonable and necessary.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)