

SENT VIA EMAIL OR FAX ON  
May/21/2012

## True Decisions Inc.

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/17/2012

**IRO CASE #:**

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

ODG EMG BIL upper extremities 95900 95904 (99203 PNR)

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

Anesthesiology/Pain Management

**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

Utilization review findings 03/29/12

Utilization review findings 04/19/12

Preauthorization reconsideration request 04/12/12

Designated doctor evaluation 01/12/07 and neuropsychiatric component of designated doctor evaluation 09/03/09

MRI cervical spine 09/20/06, 07/08/08, 08/06/09, 01/14/11

MRI lumbar spine 04/15/07

Electrodiagnostic testing bilateral upper extremities 04/20/09 and electrodiagnostic studies bilateral lower extremities 01/25/08

Epidural steroid injection C6-7 06/02/09 and 11/16/06

Epidural steroid injection L5-S1 06/13/07 and 10/23/07

Office notes 12/05/06-03/23/12

Emergency department records 11/12/11

Progress note 02/08/11 and 12/16/10

X-rays thoracic and lumbar spine 08/24/06

X-ray cervical spine 08/24/06

MRI brain 10/31/06

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female who was injured on xx/xx/xx when box fell and hit her in back of neck, upper back, and low back. She has been treated with extensive physical therapy,

medications, and epidural steroid injections to cervical and lumbar spine. The patient has also undergone multiple diagnostic / imaging studies including several MRI scans of cervical spine, EMG/NCV of bilateral upper extremities and bilateral lower extremities, MRI lumbar spine, MRI brain, and x-rays of cervical, thoracic, and lumbar spine. The claimant was seen by on 03/23/12 with complaints of pain in posterior neck area radiating to the upper extremities left greater than right. Physical examination reported tenderness right and left facet joint C4, C5, C6, C7. Sensation was decreased on left L5-S1 and left C5-7. Gait was limping, slow. The claimant was recommended to undergo EMG to evaluate worsening radicular pain.

A pre-authorization request for EMG of the bilateral upper extremities was reviewed on 03/29/12 and per physician advisor non-authorization was given. It was noted that per latest medical report dated 03/23/12 the claimant presented with neck pain. Physical examination showed decreased sensation over the left C5-7 and normoactive deep tendon reflexes. It was noted that the claimant had a previous EMG, but the electrodiagnostic report was not included in the submitted records. Also the objective findings in this claimant did not suggest worsening or progression of condition in order to warrant repeat diagnostic studies. Furthermore the record did not provide objective documentation of failure of an optimized pharmacotherapy in this claimant, utilizing VAS score with and without medication intake, and recent or ongoing rehabilitation efforts. Hence medical necessity of EMG of the upper extremities is not established at this point.

An appeal request for EMG of the bilateral upper extremities was reviewed on 04/19/12 and per physician advisor non-authorization was given for repeat EMG of the bilateral upper extremities. Reviewer noted per medical report dated 03/23/12 the claimant complained of pain in the posterior neck radiating to the upper extremities, which is more to the left than the right side. Physical examination revealed tenderness over the paravertebral, trapezius and occipital regions with decreased range of motion. Sensation was also decreased over the left C5-7 dermatome but with normoactive deep tendon reflexes. It was noted that initial request for EMG of the upper extremities was non-certified due to non-submission of the previous EMG report, and non-documentation of worsening or progression of the claimant's condition and failure of conservative treatment. Updated documentation included the EMG report dated 04/20/09. However there were no additional documentations provided with regard to the claimant's changing symptoms and details on the claimant's response to conservative treatment. Moreover there were no indications of possible metabolic pathology or peripheral compression to support the utilization of EMG. Hence medical necessity has not been established and the previous non-certification is upheld.

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

The clinical data provided does not support a determination of medical necessity for repeat EMG of the bilateral upper extremities. The claimant was injured in 2006 when a box fell and hit her in the back of the neck, upper back and lower back. She was treated conservatively with physical therapy, medications and epidural steroid injections. The claimant underwent multiple diagnostic studies including MRI of the cervical spine as well as electrodiagnostic testing of the bilateral upper and lower extremities. EMG performed 04/20/09 showed evidence of moderate acute left C7-8 radiculopathy. The claimant underwent epidural steroid injections at the C6-7 level on 11/16/06 and again on 06/02/09. It appears that the claimant has been diagnosed with cervical radiculopathy and has been treated for radiculopathy with epidural steroid injections. There is no indication that repeat electrodiagnostic studies will advance the diagnosis or alter the treatment plan. According to Official Disability Guidelines, cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, but they have been suggested to confirm a brachioplexus abnormality or some problem other than cervical radiculopathy; however, these studies can result in unnecessary overtreatment. Accordingly the previous denials were correctly determined, and 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)