True Decisions Inc.

An Independent Review Organization
2002 Guadalupe St, Ste A PMB 315
Austin, TX 78705
Phone: (512) 879-6332
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
NCS of bilateral upper extremity

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
PM&R and Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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
Fax cover 06/25/12
Initial pre-auth request 06/04/12
EMG 05/21/12
Subsequent medical report 05/17/12
EMG/NCV 06/22/10
Fax cover 07/31/12
Reconsideration request 07/31/12
Pre-authorization determination 07/02/12
Preauthorization review determination 08/07/12
Fax cover 09/06/12
IRO request form
MDR-IRO preauthorization request 09/06/12
Fax cover sheet 09/19/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male whose date of injury is xx/xx/xx. Records indicate the claimant was working when he had onset of pain. Records indicate treatment has included activity restriction, oral medications, physical therapy, injection therapy, and operative intervention. The claimant underwent left shoulder arthroscopic rotator cuff repair on 11/03/10. He also underwent ACDF C5-6 on 03/23/11. Records indicate the claimant also participated in chronic pain management program. Per medical report dated 05/17/12 the claimant reported

persistent neck and bilateral shoulder pain. He reported numbness of right hand, and weakness of left upper extremity. Examination of cervical spine revealed presence of surgical scar. There is tenderness of cervical paraspinals bilaterally. Tenderness was noted at bilateral trapezius upon palpation. Cervical range of motion was restricted. There was decreased sensation of right upper extremity. Left shoulder examination revealed well healed surgical incision. Left shoulder range of motion was decreased. There was tenderness of left shoulder upon palpation. There was weakness of left shoulder. Examination of right shoulder revealed tenderness at anterior and lateral aspect upon palpation. There was decreased range of motion of right shoulder, positive impingement sign and weakness of right shoulder. The claimant was referred for EMG/NCV of upper extremity.

A request for NCS of bilateral upper extremities was not certified as medically necessary on 07/02/12 noting the claimant was declined surgery and thus was not a candidate for any future medical care, thus a chronic pain management program was approved. It was noted since the claimant has ruled out future surgery; additional investigational studies are not supported. It was further noted the claimant had ACDF for C5-6 radiculopathy, thus the EMG findings of 05/21/12 were expected. There is no medical necessity for NCS studies when the problem at hand is chronic cervical radiculopathy. Per Official Disability Guidelines NCS are not medically necessary in work up of radiculopathy. It was further noted that does not meet minimal Official Disability Guidelines documented qualifications of performance of electrodiagnostic studies. Also NCS studies done 06/22/10 were essentially normal.

A reconsideration / appeal request for NCS of bilateral upper extremities was not certified as medically necessary per review dated 08/07/12 noting no additional clinical findings were submitted with appeals correspondence. It was noted addressed the issues brought up by previous reviewer but his objections to denial did not impact the prior non-authorization. The claimant has been approved for chronic pain management program and is currently attending CPMP indicating all lower levels of treatment have been exhausted. There is no rationale for medical necessity of NCS given the claimant's current status. No red flags were documented to substantiate medical necessity. Non-approval of NCS studies was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for NCS of bilateral upper extremities is not supported as medically necessary based on documentation presented. The claimant is noted to be status post ACDF at C5-6 performed on 03/23/11. EMG dated 05/21/12 reported evidence consistent with active and chronic radiculopathy process involving the bilateral C5 nerve root levels with relatively inactive radiculopathic findings at bilateral C6 nerve root levels. Per Official Disability Guidelines neck and upper back chapter, nerve conduction studies are not recommended as there is minimal justification for performing nerve conduction studies when a patient is presented to have symptoms on the basis of radiculopathy. Claimant underwent recent EMG which identified findings consistent with active and chronic radiculopathy of the cervical spine. The request as submitted does not meet Official Disability Guidelines criteria, and medical necessity is not established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES