

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCV studies of bilateral upper extremities

A 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)

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
Clinical notes dated 01/07/13 through 02/15/13
Previous utilization reviews dated 01/09/13 and 02/20/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his right shoulder. The clinical note dated 01/07/13 details the patient being recommended for an EMG/NCV study of both the upper extremities. The clinical note dated 02/13/13 details the patient complaining of right shoulder, neck and back pain. The note did detail the patient utilizing Hydrocodone, Gabapentin, and Cyclobenzaprine for ongoing pain. Upon exam the patient was able to demonstrate 5/5 strength with the upper extremities. Reflexes were noted to be 2+ in the right extremities and absent in the left extremities specifically at the elbow and wrist. The patient did demonstrate range of motion deficits, specifically with external rotation on the right.

The previous utilization review dated 01/09/13 for an EMG/NCV bilateral upper extremities resulted in a denial as no information was submitted regarding the patient's neurological involvement regarding the upper extremities.

The utilization review dated 02/20/13 for an EMG/NCV study of upper extremities resulted in a denial as no information was submitted regarding the patient's imaging studies or

conservative treatments regarding the patient's significant findings.

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

The documentation submitted for review elaborates the patient complaining of right upper extremity pain associated with range of motion deficits. The Official Disability Guidelines recommend an EMG/NCV study provided the patient meets specific criteria to include demonstration of submitting clinical findings. However, the Official Disability Guidelines does not recommend NCV studies of the upper extremities as there is minimal justification for performing these studies when the patient is presumed to have symptoms on the basis of radiculopathy. The patient is noted to have significant findings of diminished reflexes in the upper extremities, specifically the elbow and wrist. Given the radiculopathy component noted in the upper extremities, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the request for an EMG/NCV study of the bilateral upper extremities is not recommended as medically necessary.

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)