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Notice of Independent Review Decision

DATE OF REVIEW: March 31, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat electromyography/nerve conduction velocity studies (EMG/NCV) of the left upper extremity.

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

M.D., Board Certified in Orthopedic Surgery.

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)

The requested repeat electromyography/nerve conduction velocity studies (EMG/NCV) of the left upper extremity is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx to his left chest. A magnetic resonance imaging (MRI) of the cervical spine dated 10/14/13 revealed mild congenital narrowing mid cervical spine on the basis of short pedicles; C2-3, mild facet arthropathy, no neural encroachment; C3-4, minimal noncompressive protrusion/spondylosis, slight foraminal narrowing leftward, moderate facet arthropathy; C4-5, small central protrusion about 3.2 mm, no

frank central stenosis, moderate facet arthropathy; C5-6, moderate facet arthropathy, mild foraminal narrowing bilaterally, subtle broad based mixed protrusion and mild uncovertebral hypertrophy, no definite neural effacement; C6-7, mild facet arthropathy, small noncompressive mixed protrusion, about 2.6 mm without frank neural effacement; C7-T1, moderate facet arthropathy, no disc herniation or compressive disc disease and slightly prominent retrocerebellar cerebrospinal fluid (CSF) like signal, likely prominent cisterna magna. The physical therapy re-evaluation dated 12/12/13 noted the patient had 20% improvement with physical therapy. The patient's cervical spine flexion was 45 degrees, extension 25 degrees, lateral flexion 40 degrees bilaterally, right rotation 51 degrees and left rotation 45 degrees. The clinical note dated 2/13/14 noted the patient had a previous electromyography (EMG). The provider noted that after review of the EMG and MRI, the patient did not have any discs that showed dramatic neural foraminal encroachment. The provider noted the nerve study was two months prior and it did not have any dramatic changes. The provider noted the patient had numbness, tingling, and aching, as well as pain and swelling into the shoulders. The provider recommended repeating the electrodiagnostic testing.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the denial letter dated 3/7/14, the URA indicated that repeating the diagnostic EMG cannot be supported on the basis of the symptoms, physical examination findings and outcome of the initial study noted.

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

The Official Disability Guidelines indicate that nerve conduction velocity studies (NCV) are not recommended to demonstrate radiculopathy, if radiculopathy has already been clearly identified by EMG and obvious clinical signs. Guidelines also indicate that NCV is recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. The Official Disability Guidelines further indicate that EMG is recommended to assess for radiculopathy. According to the medical records submitted for review, the patient underwent electrodiagnostic testing two months prior to the 2/13/14 office visit which did not indicate any neurologic deficits. Although the record notes that the patient had tingling, aching, pain and swelling in the shoulders, there was no indication of objective findings of radiculopathy upon physical examination. Additionally, there is a lack of evidence demonstrating that the patient had a significant change in presentation or symptoms that would indicate the patient's need for a repeat electrodiagnostic study. As such, the requested left upper extremity EMG/NCV testing is not medically necessary for the treatment of the patient's medical condition. In accordance with the above, I have determined that the requested EMG/NCV of the left upper extremity is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**