

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Oct/9/2014

**IRO CASE #:**

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

Bilateral upper extremity EMG/NCS

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

Board Certified Orthopedic Surgeon

**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.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reported an injury to her neck and both shoulders as a result of a fall on xx/xx/xx. The clinical note dated 04/25/14 indicates the patient complaining of a dull to sharp aching pain at the shoulders and occipital region. The note indicates the patient utilizing Flexeril for pain relief. The operative note dated 07/10/14 indicates the patient undergoing an L5 epidural injection on the right. The clinical note dated 08/12/14 indicates the patient continuing with neck and bilateral shoulder pain. Upon exam, the patient was able to demonstrate 25% of range of motion throughout the cervical region. Provocative testing resulted in essentially normal findings. There is an indication the patient had undergone an MRI of the cervical spine on 07/03/14 which revealed a broad based disc osteophyte complex at C5-6. Narrowing of the spinal canal was also identified. Severe bilateral neuroforaminal stenosis was further revealed. The clinical note dated 08/25/14 indicates the patient continuing to work on an everyday basis. The clinical note dated 09/02/14 indicates the patient being recommended for an EMG/NCS study of both upper extremities.

The utilization reviews dated 09/04/14 & 09/11/14 resulted in denials as insufficient information had been submitted regarding the patient's radiculopathy.

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

The documentation indicates the patient complaining of cervical and bilateral shoulder pain. Electrodiagnostic studies are indicated in the upper extremities provided the patient meets specific criteria to include significant findings indicating radiculopathy following a full course of conservative therapy. No information had been submitted regarding the patient's strength, reflex, or sensation deficits in the upper extremities. Given the lack of information regarding the patient's confirmation of radiculopathy in the upper extremities, this request is not indicated as medically necessary.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**