



MedHealth Review, Inc.  
661 E. Main Street  
Suite 200-305  
Midlothian, TX 76065  
Ph 972-921-9094  
Fax (972) 827-3707

## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 10/19/14

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a bilateral upper extremity EMG/NCS.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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 reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a bilateral upper extremity EMG/NCS.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was noted to have been involved in a motor vehicle accident. In addition to nonoperative treatment, she underwent a fusion at the L5-S1 level in the year 2000, a C4-6 fusion in 2001 and a multilevel artificial disc replacement procedure at L3-4 and L4-5 in 2005. The most recent records submitted for review include the note from September 8, 2014. Treatments had included medications, restricted activities and cervical rhizotomies. The painful subjective radicular-type complaints were noted, as were the 1+ upper extremity reflexes, with upper extremity strength 5/5 except 5-/5 intrinsics. X-rays revealed healed

fusions and no hardware issues. Denial letters discussed the lack of neurologic or other red flags and the lack of recent conservative treatment.

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

Evidence of severe or progressive neurologic findings has not been submitted. In addition, recent comprehensive treatments were documented to have been tried and failed. Therefore the considered diagnostics have not met the applicable ODG criteria referenced below and are therefore not medically necessary.

Electromyography/EMG: Recommended only in cases where diagnosis is difficult with nerve conduction studies (NCS). In more difficult cases, needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies (NCS). There are situations in which both electromyography and nerve conduction studies need to be accomplished, such as when defining whether neuropathy is of demyelinating or axonal type. Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. Electromyographic examinations should be done by physicians. (Utah, 2006) Surface EMG is not recommended. See Electrodiagnostic studies.

Nerve Conduction Studies/NCS: Recommended only in cases where diagnosis is difficult with nerve conduction studies (NCS). In more difficult cases, needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies (NCS). There are situations in which both electromyography and nerve conduction studies need to be accomplished, such as when defining whether neuropathy is of demyelinating or axonal type. Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. Electromyographic examinations should be done by physicians.

**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 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)