

# Becket Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/08/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: EMG/NCV of the bilateral upper extremities

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is this reviewer's opinion that medical necessity for EMG/NCV of the bilateral upper extremities in this case is not established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who sustained an injury on xx/xx/xx. The patient is noted to have had multiple surgical procedures for the lumbar spine and has a spinal cord stimulator implanted. The patient is reported to have had prior carpal tunnel releases as well as shoulder procedures. There were electrodiagnostic studies from 05/01/08 which noted no evidence for radiculopathy with left median nerve root entrapment at the wrist. There was also subtle swelling of the ulnar sensory nerve across the elbow; however, this was in the upper limits of normal. CT myelogram studies of the cervical spine completed on 07/08/13 noted extra dural defects at C4-5 and C5-6 with contrast under filling of the right C6 nerve root. There was mild effacement of the anterior aspect of the thecal sac at C4-5 due to a 1.5mm disc protrusion. No canal or foraminal stenosis at this level was noted. At C5-6, there was a 2mm disc protrusion effacing the right side of the anterior aspect of thecal sac with a patent canal and mild right foraminal stenosis. No other pertinent findings were noted. The patient has completed a pain program through March of 2014. The most recent report on 06/24/14 noted continuing complaints of neck pain radiating to the left upper extremity as well as left shoulder pain and low back pain. There was associated weakness, spasms, numbness, swelling, and headaches reported. The patient's physical examination was limited and within normal limits. The recommendations did not include electrodiagnostic studies and there was no specific rationale regarding this testing.

The proposed EMG/NCV studies of the bilateral upper extremities were denied by utilization review on 07/29/14 as there was no information noted in the most recent evaluation showing evidence of worsening neuropathic or radiculopathy to warrant repeat studies.

The request was again denied by utilization review on 07/30/14 due to lack of updated findings showing worsening neurological symptoms that would warrant repeat testing.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for a long history of neck, low back, and upper extremity complaints. The patient is noted to have received an extensive amount of tertiary level pain management to include chronic pain management as well as a spinal cord stimulator implant. The patient's clinical documentation did note some nerve root under filling at C5-6 due to disc pathology in July of 2013. However, the most recent evaluation on 06/24/14 did not identify any pertinent physical examination findings to include motor weakness, sensory loss, or reflex changes that would support a worsening or new radiculopathy. There were also no objective findings regarding a recurrence of peripheral neuropathic findings that would support repeat EMG and NCV testing. 06/24/14 clinical report did not specify why electrodiagnostic studies would be indicated or would provide any new information that would help guide the patient's course of treatment. Therefore, it is this reviewer's opinion that medical necessity for EMG/NCV of the bilateral upper extremities in this case is not established and the prior denials are upheld.

**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)