

# Health Decisions, Inc.

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**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** NCS Left Upper Extremity EMG Left Upper Extremity

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** American Board Certified Physician in Physical Med. and Rehab with over 20 years' experience.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

(Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a male who sustained an injury related to a motor vehicle accident. Diagnosis Sprain of the neck, Spinal stenosis cervical region, Radiculopathy cervical region. Treatments to date: The patient was diagnosed with a meniscal tear which was surgically corrected. He has completed some conservative care with PT visits for the c-spine, medication, and diagnostics. Cervical MRI showed severe multilevel DDD request is for NCS Left Upper Extremity EMG Left Upper Extremity because patient is still experiencing pain and symptoms of radiculopathy of the neck.

XX/XX/XX: Daily Note: Pt was referred to PT for neck pain and strain after MVA on XX/XX/XX where his work truck was struck on the driver's side and rolled by an 18 wheeler. Patient was the passenger in the truck. He sustained injuries to the neck, left knee and right hip/thigh area. He was sent for PT for his neck pain. Pt reports pain along his upper trapezius regions with movement, but states his pain is minimal when he restricts cervical spine motion. Patient's goal is to improve movement and reduce pain. At this time pt is unable to work secondary to dysfunction. Pt rates pain 6/10. The client tolerated today's treatment / therapeutic activity without complaints of pain or difficulty

XX/XX/XX: Visit list: Patient is a male. He presents with pain, stiffness, decreased rom, swelling, instability and weakness on the left side. He states that the symptoms have been acute traumatic and began on XX/XX/XX. He indicates the injury occurred at work. He is on Workers Comp. XX states that the symptoms began as the result of L knee struck the dash board. The symptoms occur constantly. The problem is unchanged. Currently the patient states that the symptoms are moderate. The pain is described as aching, burning, deep, localized, piercing and sharp. The symptoms occur with activity. The patient indicates that the pain is located in the left knee lateral JL on the left side. The pain does not radiate. PT was passenger involved in restrained MVA with speeding a 18 wheeler. truck was struck from behind at stand still and flipped over on its side. PT reports no relevant past med/surg/psych history.

Assessment: Knee- Gait normal, Alignment- Left neutral, Negative swelling, Flexibility normal. Maximum tenderness- Left lateral joint line, Patella exam- Crepitation negative. Patella position neutral, tilt equal, McMurray's positive. Plan: Assessment Acute Medial meniscus tear. S/p acute left knee mechanical symptoms of the medial lateral meniscus tear with G2 chondromalacia (old partial ACL tear) following MVA. L knee steroid injection given with good relief. Extend PT (pt has attended approx. 6 wks) Reviewed MRI/XR's brought in by pt. RTC in 2 wks for clinical re-eval. Consult to Hanger for knee brace.

XX/XX/XX: Visit list: PT has not attended PT yet as it has not been approved. PT will receive knee brace soon. Pt states that lateral knee joint is still burning despite injection "burns". Pt will return after PT is completed if pt fails PT, will consider DUA with LMD.

XX/XX/XX: MRI C-Spine without Contrast: Impression: 1. Severe multilevel degenerative disc disease with disc height loss, disc bulges and endplate spurs superimposed on congenitally small canal produced spinal stenosis at all cervical disc levels as well as C7-T1 but most severe at C4-5 and C5-6. 2. Cervical spindylotic myelopathy at C4-5 with T2 cord hyperintensity and severe cord flattening. 3. Mild cord flattening at C3-4 and severe cord flattening at C5-6 but without abnormal cord signal at these levels.

XX/XX/XX: Visit list: Pt reports that his symptoms are moderate. The pain is described as aching, deep, localized sharp and burning. The symptoms occur with activity. The patient indicates that the pain is located in the medial/lateral JL on the left side. Pt reports that steroid injection has not improved symptoms that it has worn off and that he now has some burning sensation along the JL. RTC after approval for Preop and DUA with LMD/MMD conservative therapy has failed.

XX/XX/XX: Visit list: Male presents with c/o neck pain. The pain began XX/XX/XX after he was hit while in a vehicle and car rolled. The patient complains of bilateral arm pain, right greater than left. The severity of pain 7-8/10. The patient has numbness and tingling in his arms. Pt denies bowel or bladder incontinence. The patient complains of difficulty with balance. The patient denies history of falls. Treatments include anti-inflammatory medications, physical therapy for 4 weeks without improvement. The patient has tried medications and therapy with no improvement. He has significant weakness in his upper extremities on exam. He has cord signal changes at C4-5 on the MRI and severe stenosis at C3-4, and C5-6. He is at risk for paralysis if he were to fall or get into a car accident. He is at risk for bowel and bladder incontinence. He needs surgery to fix the problem. He would benefit from a C3-4, C4-5, C5-6 anterior cervical discectomy and fusion with instrumentation. The surgery and possible complications were discussed in great detail with the patient and his family. He would like to proceed with the operation. I will obtain a medical clearance preoperatively. I will schedule the surgery once approval is obtained from TWCC.

XX/XX/XX: Visit list: Patient complains of left knee pain. The symptoms are aggravated by daily activities. XX states that the symptoms are relieved by no specific activity. In addition to left knee pain the patient is also experiencing crepitus, cracking, decreased mobility, difficulty bending and difficulty going to sleep. He has been treated with a corticosteroid injection on the left side. Pt is taking Norco 5/325mg as directed every 8 hrs for pain. Plan: Pre op for left knee scope for LMT.

XX/XX/XX: Visit list: Male presents for RLE Hematoma. The symptoms are reported as being moderate. He states the symptoms are chronic here to discuss surgery. 5x6 cm soft area on the lateral aspect of the right thigh no evidence of infection. Patient has undergone left knee surgery and is waiting for surgery of his neck. I saw him about 1 month ago for swelling of his right thigh. It was at that time painful but did not appear infected or otherwise causing an issue. Pt was able to get US done and it appears to be a motel lesion, This makes since after his trauma. This has not been resolved after 4-5 months. Will need to be I&D secondary to the pain it is causing and to the potential infection.

XX/XX/XX: Office visit: Patient returns to the office to follow up on a Workers Comp injury to the neck, right hip and left knee. T states that he is still attending PT sessions. Pt states that ortho released him on the left knee today. Pt reports that his right hip is still sore at this time. Pt is waiting for the open wound on his Right hip to heal before doing any procedures on his neck. Pt reports that he is having a needle like pain in the neck. Cervical Spine

assessment: Positive foraminal compression test bilaterally and negative foraminal distraction test bilaterally. Negative brachial plexus stretch test bilaterally and negative adsons maneuver bilaterally. ROM decreased, flexion restricted, extension restricted, rotation restricted. Thoracic paraspinal muscle tenderness ( in upper back bilaterally medial of upper scapula's) Patients knee is much improved, and Right hip is resolving. However we are at a standstill with the neck. Testing positive for radiculopathy, Scheduled NCS/EMG UE bilaterally. Return to clinic in 1 month

XX/XX/XX: Office visit: Pt returns to clinic with Chief complaint of needing to f/u on Work Comp injury to the neck, hip and knee. Pt states that he has seen improvement in the knee pain however the neck pain is still very intense. Pt also voiced that he has a wound present on the hip. The patient does not feel well. Taking Norco, Tylenol extra strength, and Sulindac for pain. Pointed out that patient is healing well discussed NCS/EMG findings WNL. Pointed out that the spinal cervical stenosis is quite stable. It is not pinching a nerve at this point. If it had not been stable he would have had nerve injury at the time of the accident. At this point he needs to start going back to work with restrictions. Go to PT for work conditioning and return to the clinic in 1 month.

XX/XX/XX: Re-evaluation: Patient is a male who is referred to PT for return to work conditioning. Pt was injured on XX/XX/XX in an MVA. He had a tear of the meniscus of his left knee, has had surgery and rehab. He injured his neck, had some PT in XX XX. Still having pain and motion loss etc. MRI shows stenosis HNP ect. He had a Hematoma on his right hip, underwent I&D, wound is healing, but has he has been cleared to perform RTWC just needs to keep the wound clean and covered. Pt is to be evaluated for RTWC. His goal is to eventually be able to resume full ADL's and work activities without limitation. No contraindications to treatment are noted.

XX/XX/XX: Office visit: Pt returns to the office to follow up on a workers compensation injury to the neck and right hip. Pt states that his right hip is still sore but his wound has healed. Pt has not been able to start PT again at this point due to pre auth. Pt states that when he bends over or when he is walking he feels like there is something rubbing on his hip. Pt back at work mopping and sweeping. Pt is slowly improving. Reassured pt regarding scar that is will not pull apart. Pointed out it is involving sq tissue and not muscle or tendons. Demonstrated stretching and exercises to do. Wife familiar with these. Increase work load and return to clinic in 5 weeks. Work Hardening not started yet.

XX/XX/XX: Office visit: Pt reports that the pain in his neck is not getting any better. Pt describes the pain as needles stabbing him. Pt states that he was in the ER last night due to pain and received a Dilaudid and Phenergan injection. Also states that he has not taken any of his Tylenol #3. Discussed with pt and his significant other on his pain, No new changes on Xray. His knee and hip are pretty much resolved on exam. His neck continues to bother him there is increased in his activity at work and with PT. I told pt that he is to have expected soreness and aches after especially after increased of load. Recommended to continue with PT and gradual increase of physical activity.

XX/XX/XX: C-Spine 2 or 3 Views: Impression: Mild to moderate degenerative changes in Cervical Spine. If symptoms are persistent or further follow-up is required, MRI would be beneficial.

XX/XX/XX: Office visit: Pt returns to the office to follow up on a workers comp injury to the neck. Pt states everything is good but his neck. Pt states when he bends his neck to the left pain shoots and radiates to the right arm. When he bends his neck to the right pain shoots and radiates to the left arm. Pt stated the pain 8/10 on the pain scale and that the pain is going down the entire left arm to the fingers. ROM decreased and movements are painful. Tender posterior and down into left trap. Pt relates story of pain worsening to the point of having to go to the ER 4 nights ago. Just got meds today from visit here 3 days ago. Start medications, no more heat treatments at PT. Return to work with restrictions. Return to clinic in 1 week. Check NCS/EMG of the left upper extremity to r/o cervical radiculopathy.

XX/XX/XX: IRO: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is non-certified. Spoke with XX and he explained patient has complained of 10/10 pain after mopping. Pain prompted a trip to ER on XX/XX/XX. PT is underway. He will await re-evaluation XX/XX/XX and reconsider EDS accordingly.

XX/XX/XX: Office visit: Pt return to the office for WC injury to the neck. Pt rates pain 7/10 and that it radiates to the left shoulder and more painful to the left shoulder than the right shoulder. Pt here because nerve study was denied and is here to find a different way to help his neck injury. Decreased ROM in the neck, Joint pain in Neck and Shoulders when mopping and Muscle weakness (LUE) Numbness in left hand and Paresthesia in Arms from time to time and in shoulders. Strength RUE normal. LUE 4/5 reduced muscle strength (hand grip and fingers) Pt symptoms seem to be worsening. Physical exam is changing for the worse. Resubmit for NCS/EMG of the Left upper extremity. Return to work with increased restrictions F/U in 1 week.

XX/XX/XX: IRO: This request is Non-certified. Regarding the request, of note, the exam findings on XX/XX/XX were unremarkable and do not represent focal neurological deficits as comparison on XX/XX/XX was similar. There was no documentation of recent conservative therapy such as PT addressing the recent objective findings or clear rationale to explain the need for additional testing given the prior normal findings from the previously documented Electrodiagnostic testing are not identified.

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

Determination: Denial of NCS/EMG of the left upper extremity is UPHELD/AGREED WITH since there is documentation on the office visit note dated XX/XX/XX of "NCS/EMG findings WNL." A repeat electrodiagnostic study 2-3 months later is not medically necessary particularly with the same, persistent neurological symptoms and signs. Therefore, the request for NCS/EMG is not medically necessary at this time.

Per ODG:

Recommended needle EMG or NCS, depending on indications. [Surface EMG](#) is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies. The later development of sympathetically mediated symptomatology however, has no pathognomonic pattern of abnormality on EMG/NCS. ([Colorado, 2002](#)) EMG and NCS are separate studies and should not necessarily be done together. In the [Carpal Tunnel Syndrome Chapter](#) it says that NCS is recommended in patients with clinical signs of CTS who may be candidates for surgery, but EMG is not generally necessary. In the [Low Back Chapter](#) and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also [Monofilament testing](#). For more information and references, see the [Carpal Tunnel Syndrome Chapter](#). Below are the Minimum Standards from that chapter. See also the [Forearm, Wrist, & Hand Chapter](#) for definitions.

**Minimum Standards for electrodiagnostic studies:** The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:

- (1) EDX testing should be medically indicated.
- (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable.
- (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.
- (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.
- (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.

(6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.

(7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. ([AANEM, 2009](#))

**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)**