

SENT VIA EMAIL OR FAX ON
Apr/13/2009

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/06/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat EMG / NCV left lower extremity; repeat muscle test left lower extremity

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 3/6/09 and 3/16/09
Management IRO Summary 3/24/09
Dr. 2/12/07 thru 3/6/09
MRI 9/21/07
X-Ray 8/14/08
OP Report 11/23/05
Healthcare 12/1/05
Neurodiagnostics 9/8/06
Dr. 9/21/06 and 9/26/09

PATIENT CLINICAL HISTORY SUMMARY

This is a lady injured on xx/xx/xx when lifting a 50 pound bag at work. She developed left leg

numbness and tingling and low back pain. An MRI in 2005 reportedly showed facet effusion at L3/4. She had some transient relief after facet injections in 2005. She continued to be symptomatic. She had a repeat MRI on 9/21/07 that showed a minimal disc bulge at L4/5, and a mild bulge at L5/S1. There was also a posterior annular tear at the lower level. There was bilateral facet hypertrophy at L4/5 and L5/S1. There was no description of any nerve root compression. There was no narrowing of the neural foramen at any level. Dr. felt she had a left L5 radiculopathy by history and examination. The emg her performed on 9/8/06 was normal. Dr. had evaluated her and reports some repeated weakness in the left EHL and left quadriceps (4+) and a positive SLR at 45 degrees. She has persistent symptoms of a radiculitis and Dr. wants to repeat the electrodiagnostic studies.

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

There are two components in electrodiagnostic testing in addition to the H&P. The first is the nerve conduction studies. The ODG does not support NCV studies in the presumption of a radiculopathy. Therefore, this component of the testing is not approved. There has been the presumptive diagnosis of a radiculopathy, but the prior studies have not shown any neurological motor loss. Her complaints are largely sensory rather than motor weakness. This would place it as a radiculitis, which does not show on EMG. Her symptoms have reportedly worsened, but there has not been any description of neurological changes (motor or sensory loss, abnormal reflexes) since the 2006 study to warrant a repeat electrodiagnostic study. Further, both MRIs did not show any disc or bone compression of the nerve root. Therefore, there is little justification for a repeat study from the material provided.

Nerve conduction studies (NCS)

Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are 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.

EMGs (electromyography)

Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended. See Surface electromyography.)

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)