



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC) MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 08/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV left lower extremity (including consult)

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

Texas State Licensed DO Board Certified Physical Medicine & Rehab physician

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 07/22/2010
2. Notice of assignment to URA 07/22/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 07/22/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 07/21/2010
6. letter 07/19/2010, 06/29/2010, fax pre-auth 07/09/2010 & 06/24/2010, referral 06/21/2010, chart notes 06/14/2010, TDI form 07/19/2010
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

The claimant is a male, who sustained a xx/xx/xx occupational lower back injury. The mechanism of injury is that he pulled on a machine, and it broke and fell on his lower back and buttocks. Presumably, he failed conservative management and underwent L4-S1 a hemilaminectomy. Preoperatively, lumbar MRI scan demonstrates an L4-5 disk protrusion with impingement on the L5 nerve root. An EMG/NCV—unofficial interpretation is left L5 radiculopathy, possible S1 motor radiculopathy. The claimant remains symptomatic with persistent postoperative left lower extremity radicular pain, and therefore, the left lower extremity EMG/NCV study is requested.

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

According to the ODG guidelines, the requested electrodiagnostic study (EMG/NCV) is not approved because according to the ODG guidelines, there must be evidence of a progression of neurologic impairment. For EMGs, the guidelines state "recommended as an option (needle, not surface). EMGs (electromyography) may



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be useful to obtain unequivocal evidence of radiculopathy after 1 month of conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. 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 a benefit in surgery with major corrective anatomic enervation, like fracture, scoliosis, or fusion, where there is significant stenosis. EMGs may be required by the AMA guides for an impairment rating of radiculopathy. (Note: Needle EMG and H-reflexes are recommended, but surface EMG and F-wave tests are not very specific, and therefore, not recommended. See surface electromyography). For nerve conduction studies, the guide states "not recommended." There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. See 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 of conservative therapy, but EMGs are not necessary if radiculopathy is clinically obvious." In summary, although the claimant is demonstrating left lower extremity focal neurological impairment, there is no documentation of any progression of neurologic impairment. Furthermore, because the clinical evidence of radiculopathy is present, there is no specific additional clinical information that can be gained from performing the requested electrodiagnostic study; therefore, the insurer's denial is upheld. There is no documentation that the claimant has received a maximum degree of conservative treatment, including physical therapy, prescribed medication, and activity modification.

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)