MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: October 12, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Electromyography/nerve conduction study to the bilateral lower extremity.

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

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

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Electromyography/nerve conduction studies to the bilateral lower extremity are medically necessary for evaluation of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 9/8/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/8/10.
3. TDI Notice of Assignment of Independent Review Organization dated 9/20/10.
4. TDI Notice to IRO of Case Assignment dated 9/20/10.
5. Medical records from MD dated 7/27/10.
6. Office visit from MD dated 7/13/10.
7. Medical records from the MRI Center including an MRI of the lumbar spine with and without contrast dated 7/1/10.
8. Letter from Care Center dated 8/4/10.
9. Denial documentation dated 8/6/10 and 8/19/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who presents with mechanical low back pain, bilateral radicular symptomatology, positive straight leg raise, absent Achilles tendon reflex on the left, and S1 numbness. The patient describes the pain as constant, moderate in intensity, severe, sharp, burning and stabbing.

The patient's provider has documented the need to rule out an ongoing radiculopathy as the patient has developed progressive loss of disc space height at L5-S1 with left greater than right foraminal encroachment. The records indicate the patient's only viable options at this time include surgery or an intrathecal pain pump.

The patient is status post two laminectomies at L5-S1, but his condition has progressed to the mechanical low back pain and left greater than right, S1 radicular complaints. A magnetic resonance imaging (MRI) scan performed at shows prior laminectomy at L5- S1 and a 4 mm posterior disc osteophyte slightly displacing the left S1 nerve root. Also noted was evidence of a hemilaminectomy at L4-5.

The patient's provider recommended electromyography/nerve conduction studies (EMG/NCS) to the bilateral lower extremity for further evaluation of his condition. The Carrier has denied coverage for this diagnostic procedure citing a lack of medical necessity.

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

The URA indicates that the requested diagnostic procedure is not medically appropriate when there is unequivocal evidence of radiculopathy. However, upon a thorough review of the available records, the evidence of radiculopathy is not unequivocal. As such, the requested EMG/NCS should be helpful in ascertaining whether this patient in fact has radiculopathy.

The provider's notes of 7/13/10 indicate the patient has obtained no relief with transcutaneous electrical nerve stimulation (TENS) or physical therapy. The provider also noted no pain relief was reported with a Medrol dosepak. Thus, it appears the patient has had an adequate trial of conservative care without benefit and the EMG/NCS has been recommended to assist in obtaining data relevant to surgical decision making. It is standard practice for spine specialists to use EMG/NCS when considering surgical interventions. Thus, it is clinically reasonable for the provider to request these studies which will assist in evaluating this patient's treatment options. While the URA indicates that the requested service does not meet Official Disability Guidelines (ODG), the ODG are not surgical guidelines and therefore do not apply in this setting.

Based upon medical judgment, clinical experience and expertise in accordance with accepted medical standards, I find the requested EMG/NCS to the bilateral lower extremity is medically necessary for evaluation of the patient's medical condition.

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

[X] 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)