

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/12/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Repeat bilateral lower extremity EMG/NCV of the lumbar spine

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

M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

**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**

ODG Treatment Guidelines

HDi, 11/10/11, 11/18/11

Precertification request 11/04/11

Office notes / examination findings Dr. 10/27/10-10/05/11

Required medical evaluation Dr. 06/28/11

Neurosurgical consultation Dr. 06/14/05

EMG report 07/20/04

Orthopedic consultation Dr. 05/13/04

MRI lumbar spine 05/04/04

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female who was working in when she lifted a 45 lb weight and injured her low back. MRI lumbar spine on xx/xx/xx revealed L3-4 annular disc bulge with flattening of the thecal sac without foraminal encroachment. At L4-5 there is a 3 mm left foraminal disc herniation with radial tear, encroaching upon the left L4 nerve root sleeve, with mild narrowing of left neural foramen. Electrodiagnostic testing performed on 07/20/04 reported evidence of left L4-5 radiculopathy. She had epidural steroid injections with minimal improvement. She has been managed with pain medications including Tramadol, Gabapentin and Flexeril. She complained of back pain with pain down left leg and weakness of left leg. Dr. performed a required medical evaluation on 06/28/11. Dr. noted that the patient has ongoing radiculopathy with increasing pain. He recommended continuing her on medications and an updated MRI as last MRI was in 2005. Dr. saw the patient on 10/05/11. She was approved to undergo repeat MRI of lumbar spine within the next week.

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

This patient sustained a lifting injury on xx/xx/xx. MRI dated 05/04/04 revealed 3 mm left foraminal disc herniation at L4-5 with radial tear in outer annulus, with encroachment upon left L4 nerve root sleeve and mild narrowing of left neural foramen. Electrodiagnostic testing on 07/20/04 reported findings consistent with left L4-5 radiculopathy. Per RME evaluation by Dr. on 06/28/11, an updated MRI was recommended to best address her case as the claimant presents with ongoing radiculopathy and escalating pain. The records indicate that MRI was authorized, but no updated MRI radiology report was submitted for review with objective evidence of neurocompressive pathology. Per ODG guidelines, EMG may be useful to obtain unequivocal evidence of radiculopathy after one month of conservative treatment, but EMG is not necessary if radiculopathy is already clinically obvious.

The records demonstrate previous positive EMG as well as clinically obvious radiculopathy on clinical examination including weakness and paresthesias in left lower extremity. Therefore, the reviewer finds the proposed repeat bilateral lower extremity EMG/NCV of the lumbar spine is not supported as medically necessary by the records submitted for review.

**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)