

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCV of the right lower extremity

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

M.D., Board Certified Orthopedic 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

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he lifted a heavy 200 lb object and injured his low back. MRI of lumbar spine on 03/24/10 reported a broad based central disc herniation at L4-5 measuring approximately 7 mm. He underwent L4-5 laminectomy / discectomy in 11/10. He reports that he got very minimal relief and continued to have back and leg pain after surgery. Repeat MRI on 02/08/11 revealed postoperative changes status post discectomy at L4-5. Previously noted disc herniation at L4-5 appears to have nearly completely resolved. There is no apparent flattening of the thecal sac. The neural foramina are patent. Small facet joint effusions are present. At L5-S1 there is circumferential disc bulge measuring 4 mm with appearance noted to be similar compared to prior examination. He was seen in consultation by Dr. on 05/26/11. He presents primarily with back pain radiating into the right lower extremity going all the way down to the calf and foot to the big toe. Back and leg pain are of equal intensity. Valsalva maneuver increases pain. Physical examination noted the injured employee stood erect and walked with a normal gait. He was able to flex to 35 degrees and extend to 5 degrees with considerable pain with extension. Straight leg raise test reproduced back pain on both sides. Neurologic testing showed full power in all lower extremity myotomes tested. Dermatomal

sensory testing was diminished over the L4 and L5 dermatomal areas on the right compared to the left. Deep tendon reflexes were within normal limits. Radiographs of the spine were obtained on this date including flexion extension views. The studies showed five non-rib bearing lumbar vertebrae. Lumbar lordosis was maintained. Disc space height was preserved. There was no spondylolysis or spondylolisthesis noted. There was no abnormal translation of rotation evident between flexion and extension.

Assessment was persistent low back pain and right lumbar radicular pain following discectomy procedure. Further evaluation with CT myelogram was recommended. Lower extremity electroneurographic studies to determine any evidence of ongoing denervation were also recommended.

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

This gentleman sustained an injury on xx/xx/xx. He underwent electrodiagnostic testing on 04/13/10, which revealed evidence of acute right L5 lumbar radiculopathy. He is status post L4-5 laminectomy discectomy performed in 11/10. On examination he had diminished sensation of the right L4 and L5 dermatomal areas. Per Official Disability Guidelines, electrodiagnostic testing may be useful to obtain unequivocal evidence of radiculopathy, but EMG is not necessary if radiculopathy is already clinically obvious. In this case radiculopathy was clinically obvious and supported by previous electrodiagnostic testing. Therefore, EMG/NCV of the right lower extremity is not found to be medically necessary by the reviewer.

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)