

US Resolutions Inc.

An Independent Review Organization
3267 Bee Caves Rd, PMB 107-93
Austin, TX 78746
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCS Bilateral Lower Extremities

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

M.D., Board Certified Orthopedic Spine Surgeon, practicing Neurosurgeon

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)

The request for EMG/NCV of bilateral lower extremities is not supported as medically necessary. However, amended request for EMG/NCV of left lower extremity is medically necessary and previous utilization review determinations are overturned.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Request for IRO dated 01/05/12

Utilization review determination dated 10/26/11

Utilization review determination dated 11/22/11

Request for EMG/NCV dated 10/19/11

Institute patient profile dated 06/02/11

Clinic notes Dr. dated 06/22/11-12/28/11

Clinic note Dr. dated 09/14/10- 05/18/11

MRI lumbar spine dated 05/05/11

CT discography dated 01/20/11

Psychological evaluation dated 12/07/10

MRI lumbar spine 10/08/10

MRI lumbar spine dated 01/20/10

Legal correspondence dated 01/11/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have date of injury of xx/xx/xx. It was reported she was helping lift a large patient that had fallen out of bed. While lifting the patient she felt pain in left lower back. After getting the claimant up she was holding him under his arm to steady and standing. Unfortunately he slipped out from under her and fell backwards grabbing her arm and pulling her. She fell such that they both fell on his bed increasing her left low back pain. The claimant subsequently underwent MRI on 01/20/10, which revealed

degenerative disease at L4-5 and L5-S1 with a midline paracentral bulge at L4-5 level. She has moderate midline and left posterior paracentral protrusion with annular tear and posterior deviation of S1 nerve root. She later underwent physical therapy and was treated with oral medications. She was later referred for lumbar discography. She subsequently underwent psychiatric evaluation with recommendation to proceed with procedure. The record includes CT post discography dated 01/20/11. At L3-4 the disc has undergone intradiscal injection and contrast essentially sequestered within the disc. The canal is widely patent. At L4-5 the disc is of minimally decreased stature Injection of contrast is sequestered predominately left anteriorly, although tiny extension of contrast to annular fibers left posterolaterally at level of exiting foramen. The L5-S1 disc is markedly decreased in stature. Contrast extends to periphery of annular fibers. Records indicate repeat MRI was performed on 05/05/11, which notes degenerative disc changes at L4-5 and L5-S1. The disc protrusion at L5-S1 is slightly more prominent. The claimant was subsequently referred to Dr. on 06/22/11. It is reported at this time her back pain is 8/10 and leg pain is 6-7/10. She reported being able to walk less than a block. She has difficulty with forward flexion and extension of no more than 10 degrees. On physical examination she is 5'9" and 245 lbs. She has limited forward flexion / extension. She has severe pain and tension signs in lower extremities and difficulty with elevation. Her strength is 4/5 in left tibialis anterior. The right is about 5-. Push up strength is diminished. Ankle jerks are depressed at 1+. Patellar tendon reflexes are 1+. She has paresthesias and numbness in lateral aspect of left foot and lateral calf region. She has grade II difficulty with forward flexion and extension. She is opined to have discogenic pain with evidence of instability and stenosis at L4-5 level. She was subsequently recommended to undergo reconstruction of L4-5 and L5-S1 levels. Radiographs of lumbar spine performed at this time are reported to show 4 mm of translation of L4-5 level. The claimant was seen in follow-up on 10/19/11 and continues to have weakness in left tibialis anterior graded 4/5. She reported numbness in posterior calf and plantar aspect of left foot worsened during nighttime. Reflexes are slightly depressed compared to right. She walks with limp. She was recommended to get EMG/NCV to check for radiculopathy.

The initial review was performed by Dr.. Dr. non-certified the request noting there is suggestion of left L5 or S1 radiculopathy and as such, bilateral study would not be medically necessary.

A subsequent appeal request was submitted requesting left lower extremity only. This was reviewed by Dr. on 11/22/11. Dr. non-certified the request noting per ODG an EMG is not recommended when there is clinical evidence of radiculopathy. He noted the claimant has radicular pain in left leg only with weakness and reflexes diminished on left. Therefore, it would not be supported under ODG and he non-certified the request.

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

The request for EMG/NCV of bilateral lower extremities is not supported as medically necessary. However, amended request for EMG/NCV of left lower extremity is medically necessary and previous utilization review determinations are overturned. The submitted clinical records indicate the claimant has long standing history of low back pain with radiation of left lower extremity. She is noted to have had positive discography at L4-5 and L5-S1. The claimant has mixed clinical presentation where performance of EMG/NCV study would clearly dictate nature and type of surgery performed. As such, the reviewer finds the request for EMG/NCS Bilateral Lower Extremities is opined to be medically necessary and consistent with current evidence based guidelines.

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)