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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/08/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
EMG/NCV, Lower Extremities

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

Official Disability Guidelines
03/05/11 – Clinical Note –MD
03/17/11-03/20/11 – Laboratory Report
03/18/11 – Trauma Consultation –MD
03/18/11 – Radiographs Left Humerus
03/20/11 – Discharge Summary
04/11/11 – Clinical Note –
05/23/11 – Clinical Note –
05/23/11 – Texas Work Status Report
06/02/11 – Radiographs Left Humerus
06/06/11 – Electrodiagnostic Studies
06/13/11 – Clinical Note –
06/24/11 – Radiographs Cervical Spine
06/24/11 – Radiographs Lumbar Spine
06/28/11 – Clinical Note –MD
07/11/11 – Clinical Note –
07/11/11 – Texas Work Status Report
07/18/11 – Radiographs Left Humerus
07/19/11 – Clinical Note –MD
07/29/11 – Clinical Note
07/29/11 – Texas Work Status Report
08/10/11 – Physical Therapy Evaluation
08/12/11 – Clinical Note
08/12/11 – Texas Work Status Report
08/26/11 – Clinical Note

08/26/11 – Texas Work Status Report
09/09/11 – Clinical Note
09/09/11 – Texas Work Status Report
09/23/11 – Clinical Note
09/23/11 – Texas Work Status Report
10/24/11 – Clinical Note
10/24/11 – Texas Work Status Report
11/17/11 – Clinical Note
11/17/11 – Texas Work Status Report
11/17/11 – Toxicology Report
12/19/11 – Clinical Note
12/19/11 – Texas Work Status Report
01/03/12 – Clinical Note –MD
01/10/12 – Mri Lumbar Spine
01/23/12 – Clinical Note –DO
01/23/12 – Texas Work Status Report
02/22/12 – Mri Cervical Spine
02/27/12 – Clinical Note –DO
02/27/12 – Texas Work Status Report
03/22/12 – Prior Review –DO
03/22/12 – Utilization Review Determination
03/26/12 – Clinical Note –DO
03/26/12 – Texas Work Status Report
03/26/12 – Toxicology Report
04/04/12 – Request For Reconsideration
04/13/12 – Prior Review –MD
04/13/12 – Utilization Review Determination
04/25/12 – Clinical Note –DO
04/25/12 – Texas Work Status Report
05/18/12 – Utilization Review Determination
05/21/12 – Clinical Note –MD
05/21/12 – Prior Review –MD
05/21/12 – Texas Work Status Report
05/22/12 – Utilization Review Determination

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained an injury on xx/xx/xx when a forklift fell on him. Electrodiagnostic studies of the lower extremities performed 06/05/11 were normal without evidence of entrapment neuropathy, peripheral neuropathy, myopathy, or active radiculopathy. Radiographs of the lumbar spine performed 06/24/11 revealed degenerative disc space narrowing involving the thoracolumbar junction. There was some disc loss at L2-3. The claimant saw Dr. on 01/03/12. The claimant complained of pain to the low back and left arm. Physical exam revealed full range of motion of the left humerus. Impingement testing was negative. There was an obvious deformity of the arm. There was a considerable lump palpated in the proximal humerus. Range of motion testing of the lumbar spine revealed flexion to 80 degrees, extension to -40 degrees, and side bending to 50 degrees. Straight leg raise was negative. Sensation was intact. There was no evidence of leg atrophy. The note states there was no radiculopathy. MRI of the lumbar spine performed 01/10/12 revealed marked loss of disc height at L1-2 with anterior bulge and spondylosis. Asymmetrical bulge and annular fissuring extended to the left posterior lateral margin, creating stenosis of the foramen and left lateral recess. There was compression upon the traversing L2 and exiting L1 nerve roots. At L2-3, there was moderate loss of disc height with a right paramedian contained herniation, compatible with a 4mm protrusion. There was marked compression upon the right traversing L3 nerve root. At L3-4, there was mild loss of disc height with loss of definition of the annulus in the nucleus and associated concentric annular bulging. At L4-5 and L5-S1, there was hypertrophy and tiny effusions of the facet joints. The claimant saw Dr. Martens on 01/23/12 with complaints of low back pain. Physical exam was not performed. The claimant was assessed with lumbar herniated nucleus pulposus with radiculopathy, resolving left humerus fracture, and cervicalgia. The claimant

was recommended for physical therapy and electrodiagnostic studies of the lower extremities. The claimant saw Dr. on 02/27/12 with complaints of neck and back pain with associated headaches. The claimant was assessed with lumbar herniated nucleus pulposus and cervicalgia. The claimant was recommended for continued physical therapy. The claimant was continued on modified duty.

The request for EMG/NCV for lower extremities was denied by utilization review on 03/22/12 due to no clinical evidence of radiculopathy. The claimant saw Dr. on 03/26/12 with complaints of neck and low back pain rating 5 out of 10. Physical exam revealed decreased range of motion of the neck and low back. The claimant was recommended for continued physical therapy. The claimant was continued on modified duty. The request for EMG/NCV for lower extremities was denied by utilization review on 04/13/12 due to a lack of evidence of neurological deficits upon recent physical examination. The request for EMG/NCV for lower extremities was denied by utilization review on 05/22/12 due to no focal neurologic deficits involving the lower extremities.

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

This man underwent initial EMG/NCV studies of the lower extremities on 06/05/11, which were normal. The claimant's continuing physical exams did not reveal any significant progressive or severe neurological changes that would reasonably require additional EMG/NCV studies to confirm a neurological diagnosis. As the documentation provided does not meet guideline recommendations for the requested service, the reviewer finds there is not a medical necessity for EMG/NCV, Lower Extremities.

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)