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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/31/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

NCV of the Bilateral Lower Extremities

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

M.D., Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Radiographic report lumbar spine 5 views dated 06/17/11

Radiographic report lumbar spine dated 06/19/11

Progress notes M.D. dated 06/22/11-09/01/11

Physical therapy plan of care and progress notes date 06/24/11-08/15/11

MRI lumbar spine dated 06/30/11

MRI lumbar spine dated 07/21/11

Lab reports 07/21/11

Peer review report dated 08/01/11

Initial medical report Dr. dated 08/25/11 and follow-up dated 02/14/12

Report of medical evaluation dated 09/12/11

MRI lumbar spine with and without contrast dated 12/30/11

Report of medical evaluation dated 02/10/12

Electrodiagnostic testing dated 02/20/12

Letter of medical necessity dated 03/01/12

Preauthorization review dated 03/05/12

Preauthorization request dated 03/07/11 (?? 03/07/12)

Adverse determination letter dated 03/12/12

Preauthorization request for reconsideration dated 03/20/12

Adverse determination letter dated 03/27/12

Preauthorization MDR/IRO dated 05/09/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained an injury on xx/xx/xx when she bent over to turn on a piece of equipment and felt a snap and burning sensation in the low back, followed by severe pain. Radiographs of the lumbar spine performed xx/xx/xx revealed no evidence of fracture

or subluxation. The intervertebral disc spaces were well maintained. There was no significant sclerosis or marginal spurring. The claimant saw Dr. on 06/22/11 with complaints of low back pain rating 7 out of 10. Physical exam revealed limited lumbar range of motion. The sacroiliac joints were not painful. There was tenderness and spasm to palpation. The claimant was able to heel and toe walk. Straight leg raise was reported to be positive. Sensation was intact. The claimant was assessed with lumbar radiculopathy and a herniated lumbar disc. The claimant was prescribed Xanax, Norco, Flexeril, and Daypro. The claimant was recommended for physical therapy. Radiographs of the lumbar spine performed 06/22/11 revealed no evidence of fractures. There was suggestion of spondylosis without listhesis at L5-S1 bilaterally.

MRI of the lumbar spine performed 06/30/11 revealed mildly diminished disc height at L4-5 with mild broad-based bulging. There was no spinal stenosis. There was minimal to mild neural foraminal and lateral canal encroachment. There was mild facet arthrosis. MRI of the lumbar spine performed 07/21/11 revealed normal alignment. There was minimal suggestion of desiccation of L4-5 and L5-S1. The claimant completed 11 sessions of physical therapy from 06/24/11 through 08/15/11. Electrodiagnostic studies performed 09/01/11 revealed evidence of mild subacute left L5 radiculopathy with signs of active denervation.

The claimant was seen for designated doctor evaluation on 09/12/11. The claimant complained of pain to the low back and bilateral lower extremities rating 7 out of 10. Physical exam revealed tenderness to palpation of the lumbar spine. Straight leg raise was reported to be positive. There was weakness of the lower extremities secondary to pain. Lumbar range of motion was restricted. There was diminished sensation of the left foot. The claimant was assessed with lumbar strain. The claimant was not placed at MMI. MRI of the lumbar spine performed 12/30/11 revealed minimal loss of signal and narrowing of the interspace at L2-3 with a 1mm diffuse annular bulge. At L4-5, there was minimal loss of signal and posterior narrowing with mild facet arthropathy. There was a synovial cyst posteriorly off the left facet joint.

The claimant saw Dr. on 02/14/12 with complaints of low back pain with pain and tingling in the bilateral feet. He claimant also reported numbness and burning sensation of the right lower extremity. Physical exam revealed atrophy of the right distal thigh. There was tenderness over the lumbar paraspinals bilaterally. Lumbar range of motion was restricted. Kemp's test was positive. There was decreased sensation of the right S1 dermatome. There was weakness of the bilateral lower extremities. The patient was prescribed Lyrica, Norco, Soma, and Daypro. Electrodiagnostic studies performed 02/20/12 revealed evidence most consistent with active and chronic radiculopathy process involving the right more than left L5 nerve root levels. The request for NCV of bilateral lower extremities was denied by utilization review on 03/12/12 as the claimant had undergone electrodiagnostic testing twice previously and neither correlated with the lumbar MRI findings. The request for NCV of bilateral lower extremities was denied by utilization review on 03/27/12 as there was no indication that the claimant's symptoms had gotten progressively worse or that surgery was being considered as an option.

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

The claimant is noted to have undergone prior EMG/NCV studies for the left lower extremity and EMG studies of the bilateral lower extremities. Both studies identified active radiculopathy in the left lower extremity. There is no significant objective evidence on physical exams of new or progressive neurological deficits that would require NCV studies for the lower extremities. The claimant's diagnostic testing and physical exams demonstrate sufficient objective evidence to support a diagnosis of lumbar radiculopathy and guidelines do not recommend further NCV studies when radiculopathy is already clinically obvious. Therefore, the reviewer finds the requested NCV of the Bilateral Lower Extremities is not medically necessary.

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)