

# Pure Resolutions LLC

An Independent Review Organization  
990 Hwy 287 N. Ste. 106 PMB 133  
Mansfield, TX 76063  
Phone: (817) 405-0870  
Fax: (512) 597-0650  
Email: manager@pureresolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Jan/29/2013

**IRO CASE #:**

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

EMG Bilateral Lower Extremities, NCS Bilateral Lower Extremities

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

Board Certified Family Practice

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
MRI lumbar spine dated 09/04/08  
Operative reports dated 10/27/09 and 11/10/09  
Clinical notes from Institute dated 04/02/10 – 12/20/12  
Prior reviews dated 12/27/12 and 01/10/13  
Cover sheet and working documents

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who has been followed for failed back surgery syndrome. The patient had a spinal cord stimulator placed in 11/09. The patient was recommended for spinal cord lead revision in 09/10. The patient also required spinal cord stimulator reprogramming several times in 2011. Clinical evaluation on 12/20/12 stated that the patient has had ongoing low back pain with increased numbness in the feet after walking 2-3 minutes. The patient reported leg pain and numbness past the knee. There was a noted complication of

diabetes on the clinical note. Physical examination revealed a balanced gait with pain and tenderness in the lumbar spine with range of motion. Abnormal sensation in a left L4-5 dermatome was noted. The patient was recommended for EMG studies of the lower extremities.

The request for bilateral lower extremity EMG/NCV studies was denied by utilization review on 12/27/12 as there was no evidence to support the use of EMG studies. The patient was reported to have possible claudication and EMG studies would not be helpful for this. It appeared that the request for NCV studies was redacted.

The request was again denied by utilization review on 01/10/13 as there was no documentation regarding recent conservative treatment and guidelines do not support the use of nerve conduction studies.

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

The requested EMG/NCV studies of the bilateral lower extremities are not recommended as medically necessary. From the most recent clinical note provided for review, there appear to be suspicions regarding neurogenic claudication which EMG studies would not help to assess. It does not appear that there was any requirement for nerve conduction studies. It was previously noted that the NCS request was redacted during peer conversation. Given the lack of any progressive or severe neurological deficits that would reasonably require updated electrodiagnostic studies to evaluate for possible radiculopathy and given the patient's suspected neurogenic claudication symptoms, EMG/NCV studies would not be supported at this time and the prior denials are upheld.

**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)