

# True Resolutions Inc.

An Independent Review Organization

500 E. 4th St., PMB 352

Austin, TX 78701

Phone: (214) 717-4260

Fax: (214) 276-1904

Email: [rm@trueresolutionsinc.com](mailto:rm@trueresolutionsinc.com)

## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Dec/20/2012

### IRO CASE #:

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

EMG, NCV Bilateral Lower Extremities

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

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:

ODG - Official Disability Guidelines & Treatment Guidelines

Legal correspondence 12/07/12

Request for IRO 12/06/12

Receipt of request for IRO 12/07/12

Utilization review determination 11/20/12

Utilization review determination 11/30/12

Letter 02/15/12

Emergency department records 02/07/12

Radiographic report chest 02/04/12

Radiographic report left knee 02/04/12

Radiographic report pelvis 02/04/12

Radiographic report right shoulder 02/04/12

Radiographic report right humerus 02/04/12

Radiographic report right hand 02/04/12

Radiographic report left hand 02/04/12

Radiographic report AP cross table lateral views right femur 02/04/12

CT head 02/04/12

Post-procedure radiographic report 02/04/12

CT angiogram neck, chest, abdomen, and pelvis 02/04/12

Radiographic report right femur 02/05/12

MRI cervical spine 02/05/12

Clinical note 04/03/12-11/14/12

Radiographic report cervical spine 04/03/12

CT myelogram cervical spine and thoracic spine 05/02/12

Procedure report cervical epidural steroid injection 08/15/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained multiple injuries as a result of a work place event occurring on xx/xx/xx. Records indicated that the claimant sustained a compression fracture at T12 and L5-6 disc herniation, right temporal laceration, right fractured femur, status post intramedullary nail placement and external fixation on 02/05/12.

Records indicated that the claimant came under the care of on 04/03/12. He presented with a significant amount of mid back pain with some neck pain and upper extremity radiculopathy and paresthesias. On physical examination, he had weakness of the wrist extensors graded as 4/5, weakness of the biceps and triceps graded as 4/5, and weakness of the deltoids graded as 4-/5. Reflexes in the left upper extremity were 2+ on the right reflexes were 1+ in the triceps and brachial radialis and 2+ for the biceps. He had negative Hoffman sign. He had significant tenderness to palpation over the thoracic spinous process. He had full range of motion at the cervical spine. He was able to heel and toe walk without difficulty. Gait changes were difficult to assess due to his femur fracture. MRI showed some mild stenosis at C5-6 and the claimant was assessed with T12 compression fracture and cervical stenosis and he subsequently was recommended to undergo CT myelography and this study was performed on 05/02/12 and it was reported that there was diminished filling of the right C6 nerve root sleeve with normal filling without significant right neural foraminal stenosis present at the C5-6 level. The post-myelogram CT noted mild congenital narrowing of the spinal canal from C3 to C5 and the narrowest AP diameter was at C5-6 measuring 9mm with minimal flattening of the spinal cord and there were small disc osteophyte complexes at C4-5 and C5-6 and C6-7 and there was moderate neural foraminal stenosis at multiple levels. There was no severe stenosis or nerve root compression and in regard to the cervical spine, there was a subacute to chronic superior endplate compression fracture at T12 and the claimant was subsequently recommended to undergo a right sided C5-6 selective nerve root block which was performed on 08/15/12. Post-procedurally, the claimant was reported to have several hours of decreased pain and then a return to the pre-injection level. The claimant was seen in follow up on 10/10/12 and he reported a reduction in his sharp pains. He had some complaints of suboccipital pain and paresthesias in both forearms. Records indicated that the claimant was participating in physical therapy.

On 11/14/12, the claimant was seen in follow up and he was noted to have persistent complaints and a failure to significantly improve over the last seven months. On physical examination, lower extremity strength and reflexes were symmetrically present and sensation was intact and the claimant subsequently was recommended to undergo electrodiagnostic studies of the lower extremities and he was further recommended to undergo repeat MRI.

The initial review was performed on 11/20/12 who non-certified the request, noting that the objective physical examination findings did not document any significant clinical findings of loss of sensation, loss of strength, or change in reflexes and he noted that there was no documentation of the claimant having any leg radicular symptoms to support the medical necessity for electrodiagnostic studies.

The appeal request was performed on 11/30/12 who non-certified the appeal request and noted that there was no evidence of clinical findings on examination which would cause concern for radiculopathy stemming from the lumbar spine or a peripheral neuropathy in the lower extremities and, as such, the request for EMG/NCV could not be supported.

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

The request for EMG/NCV study of the bilateral lower extremities is not supported as medically necessary. Per the Official Disability findings, there must be objective evidence of radiculopathy on physical examination as well as evidence of neurocompression on imaging studies. There was no evidence provided which would indicate that the claimant has

neurocompressive lesions on the lumbar spine and the physical examination is grossly normal in terms of the lower extremities and shows no evidence of an active lumbar radiculopathy. Therefore, based upon the Official Disability Guidelines, the request would not be supported as 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)