

Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/01/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: EMG/NCV bilateral feet

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M. D. Board Certified Orthopedic Surgeon

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. It is the opinion of the reviewer that the request for an EMG/NCV of the bilateral feet is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year old female who reported an injury regarding her left lower extremity. The initial encounter on the date of injury, xxxxx, details the patient complaining of left ankle pain with associated swelling and bruising. The patient stated that the initial injury occurred when she lost her balance and twisted her left foot and ankle. The patient described a popping sensation. The patient was noted to be ambulating with a limp favoring the left lower extremity. The MRI of the left ankle dated 08/24/11 revealed a minimal to moderate amount of swelling at the subcutaneous fat along the medial margin of the ankle and the adjacent distal shaft of the tibia. The operative report dated 11/17/11 details the patient undergoing an arthroscopic debridement at the left ankle. The electro-diagnostic studies dated 05/21/12 revealed normal findings. No electrical evidence of peripheral nerve involvement was noted. The operative report dated 08/15/12

details the patient undergoing a L4-5 sympathetic block. The clinical note dated 11/27/12 details the patient complaining of a shooting pain in the left foot, specifically at the lateral aspect and into the ankle. The patient is further noted to have complaints of numbness and tingling in the foot. The note details the patient having completed 11 physical therapy sessions as well as a work conditioning program. The MRI of the left ankle dated 12/27/12 revealed tenosynovitis of the posterior tibial tendon. Effusion was noted at the tibiotalar and subtalar area. The previous utilization review dated 12/27/12 resulted in a denial secondary to a lack of findings revealed on previous studies.

The utilization review dated 01/30/13 also resulted in a denial secondary to a lack of results from previous diagnostic tests.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of ongoing left lower extremity pain. The Official Disability Guidelines recommend EMG studies of the lower extremities provided the patient meets specific criteria to include completion of 1 month of conservative therapy. However, the Official Disability Guidelines do not specifically recommend NCV studies of the lower extremities as there is minimal justification for performing these studies when the patient is presumed to have symptoms on the basis of radiculopathy. The patient is noted to have numbness and tingling in the lower extremities. Given the radiculopathy component noted in the lower extremities, this request does not meet guideline recommendations. As such, it is the opinion of the reviewer that the request for an EMG/NCV of the bilateral feet is not recommended 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)