

# 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:** Sep/05/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** EMG/NCV for the right lower extremity

**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 EMG/NCV for the right lower extremity is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical note dated 01/10/11  
Clinical note dated 02/11/11  
Clinical note dated 05/01/11  
Clinical note dated 07/21/11  
Clinical note dated 08/23/11  
Clinical note dated 09/06/11  
Clinical note dated 09/20/11  
Preauthorization request dated 10/07/11  
Clinical note dated 01/10/12  
Clinical note dated 02/23/12  
Clinical note dated 06/28/12  
Clinical note dated 07/12/12  
Preauthorization request dated 08/06/13  
Previous utilization reviews dated 06/18/13, 07/10/13, 08/13/13, & 10/25/11  
Previous IRO dated 11/22/11  
Authorization request dated 09/11/11  
Decision and order note dated 02/14/11

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury regarding his low back. The clinical note dated 01/10/11 details the patient complaining of low back pain with radiating pain into the right hip and leg. The note details the patient stating the initial injury occurred when he was riding a bus and the bus had to stop before crossing the railroad tracks when it was rear-ended. The patient sustained low back, right leg, and right hip injuries. The patient rated the pain as 9/10 at that time. The clinical note

dated 08/23/11 details the patient continuing with low back pain. The patient stated that all ranges of motion throughout the lumbar spine were noted to be painful. The note does detail the patient having undergone an MRI of the lumbar region on 08/20/10 which revealed an L4-5 disc protrusion. The clinical note dated 06/28/12 details the patient continuing with 5-9/10 pain. No strength deficits were noted in the upper extremities. The note does detail the patient having been recommended for physical therapy. The letter of request dated 08/06/13 details the patient being recommended for an EMG/NCV study.

The previous utilization review dated 07/10/13 resulted in a denial for the use of an EMG/NCV study as no previous studies were submitted regarding a radiculopathy component.

The previous utilization review dated 08/13/13 resulted in a denial for an EMG/NCV study of the right lower extremity as no neurologic deficits were noted by clinical exam.

**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 low back pain with radiation of pain to the lower extremities. An EMG/NCV study would be indicated provided the patient meets specific criteria to include significant clinical findings indicating a radiculopathy component noted in the lower extremities. No information was submitted confirming the patient's radiculopathy component. Additionally, there is a lack of information regarding any conservative treatments regarding the patient's low back complaints. Given that no information was submitted regarding the patient's specific complaints of radiculopathy, this request does not meet the necessary criteria. As such, it is the opinion of the reviewer that the request for EMG/NCV for the right lower extremity 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)