

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jun/24/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** EMG/NCS of the bilateral lower extremities

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

**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 requested EMG/NCS of the bilateral lower extremities are not indicated

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his low back. The CT myelogram of the lumbar spine dated 09/11/13 revealed an epidural impression at L4-5. A broad based disc herniation with abutment at both the L4 nerve roots was also identified. A disc herniation was further revealed at L5-S1 with moderate bilateral foraminal stenosis and mild abutment of both L5 nerve roots in the neuroforamina. The clinical note dated 08/21/12 indicates the patient having undergone an x-ray of the lumbar spine which revealed instability at the L5-S1 level. The MRI of the lumbar spine dated 04/25/13 revealed a disc herniation at L5-S1 with compression of the left L5 nerve root. A broad based disc herniation was also identified at L4-5 with compression of both L4 nerve roots. The clinical note dated 05/28/13 indicates the patient being recommended to proceed with a surgical intervention secondary to the instability and bilateral sciatica. The operative report dated 09/11/13 indicates the patient undergoing a laminectomy, facetectomy, and discectomy at L5-S1 and L4-5 bilaterally. The clinical note dated 02/25/14 indicates the patient being recommended for a postoperative physical therapy course. The patient was also recommended for a bone growth stimulator. The operative note dated 03/06/14 indicates the patient undergoing an L4-5 and L5-S1 revision and removal of a transmitter unit and electrodes. The clinical note dated 04/01/14 indicates the patient ambulating with an antalgic gait. The patient was being recommended for a spinal cord stimulator at that time. The clinical note dated 04/25/14 indicates the patient continuing with an antalgic gait. The patient had complaints of radiating pain to both lower extremities, left greater than right.

The utilization review dated 04/29/14 resulted in a denial for electrodiagnostic studies as the patient was identified as having significant findings confirming radiculopathy in the lumbar spine.

The utilization review dated 05/29/14 resulted in a denial as minimal justification has been identified for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient continuing with low back pain despite a previous surgical intervention. EMG studies are indicated for patients who have shown evidence of radiculopathy after a 1 month course of conservative therapy. There is an indication the patient has radiating pain into both lower extremities. However, no information was submitted regarding the patient's reflex, strength, or sensation deficits. Additionally, it is unclear if the patient has completed any recent conservative treatments as no therapy notes were submitted for review. As such, it is the opinion of the reviewer that the requested EMG/NCS of the bilateral lower extremities are not indicated for this patient at this time.

**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)