

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Feb/11/2014

**IRO CASE #:**

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

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery; Fellowship Trained Spine 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 this reviewer's opinion that the request for EMG/NCS of the bilateral lower extremity would not be medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Handwritten clinical reports dated 08/01/95 – 12/05/11

Employer's first report of injury or illness dated xx/xx/xx

Designated doctor evaluation dated 10/13/11

Physical therapy reports dated 02/28/11 – 04/15/11

Functional capacity evaluation dated 11/01/13

Functional capacity evaluation dated 03/20/12

Radiographs of the lumbar spine dated 11/14/11

Functional capacity evaluation dated 02/28/13

Psychological evaluation date 09/24/13

MRI of the lumbar spine dated 08/07/06

CT of the lumbar spine dated 04/10/13

Clinical reports dated 02/26/13 – 10/11/13

Clinical report dated 08/13/13

MRI review dated 08/14/13

Utilization review reports dated 01/10/14 & 01/21/14

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who originally sustained an injury on xx/xx/xx. The patient has been followed for ongoing complaints of chronic low back pain. The patient was seen on 08/15/13 continuing with complaints of low back pain radiating to the right lower extremity. The patient is noted to have had a prior surgical procedure in 2008 followed by failed postoperative treatment. The most recent CT scan of the lumbar spine from 04/10/13 demonstrated prior surgical changes from L4 to S1 consistent with posterior fusion and instrumentation. The patient's physical examination at this visit demonstrated a positive Lesegue's sign to the right at 45 degrees. There were hypoactive

reflexes in the right knee reflex as well as absent posterior tibial tendon reflexes. There was also mild weakness at the quadriceps to the right without atrophy. The patient was further followed for rehabilitation through October of 2013 with continuing chronic complaints of low back pain. Letters indicated the patient was referred back for potential surgical intervention.

The requested electrodiagnostic studies for the lower extremities was non-certified by utilization review on 01/10/14. Per the report, the patient's radicular findings and diagnostic imaging is consistent with radiculopathy and there were no indications for further electrodiagnostic studies.

The request was again non-certified by utilization review on 01/21/14 as there was no evidence for justification of electrodiagnostic studies due to the clinically obvious radiculopathy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for long term chronic low back pain stemming from earlier surgical intervention. Based on the patient's most recent assessment in August of 2013, there were clear findings consistent with lumbar radiculopathy that would be consistent with the provided imaging studies. Given the lack of any updated clinical exam findings showing any potential changes in the lower extremity exam, it is unclear how electrodiagnostic studies would at this point in time provide any additional information regarding the patient's neurological findings that would help guide a course of treatment for the patient. Given the positive physical examination findings for a clinically obvious radiculopathy, it is this reviewer's opinion that the request for EMG/NCS of the bilateral lower extremity would not be medically necessary. Therefore, 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)