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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: EMG

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 the opinion of this reviewer that the requested EMG is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his neck and low back when he was involved in a motor vehicle accident. MRI of the cervical spine dated 07/09/13 revealed minimal diffuse disc bulge at C4-5 and C5-6 with mild diffuse disc bulge at C6-7 causing mild central canal stenosis and minimal bilateral neural foraminal stenosis. MRI of the thecal sac dated 08/23/13 revealed mild to moderate spinous deformity, most pronounced at T11-12. Electrodiagnostic studies on 10/31/13 revealed essentially normal findings. No evidence of lumbar radiculopathy or lumbosacral plexopathy identified. Clinical note dated 01/10/14 indicated the patient having significant surgical history involving low back surgery in 1989. The patient reported worsening pain at night which woke him. The patient was unable to walk more than one block at a time secondary to severe pain and fatigue. The patient utilized Tramadol, Hydrocodone, Celebrex and Ultracet for pain relief. Weakness was diffuse in the left upper extremity rated at 4/5. Reflexes were normal. Tenderness was identified with the paraspinal musculature. Sensation was normal in all extremities. Clinical note dated 06/19/14 indicated the patient being recommended for EMG. Clinical note dated 07/10/14 indicated the reasoning for the requested EMG was to rule-out radiculopathy. Utilization review dated 06/25/14 resulted in denial, as no information was submitted regarding radiculopathy. There was mention of a 4/5 strength regarding diffuse strength deficits in the left upper extremity. However, no information was submitted regarding the specific distribution of the strength deficits. Additionally, no specific dermatome was identified. No specific information was submitted regarding reflex or sensation deficits in a particular dermatome. Utilization review dated 07/25/14 resulted in a denial for the EMG of the bilateral upper extremities, as no information was submitted regarding any radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient complained of cervical spine and lumbar spine pain. EMG of the upper extremities is indicated, provided that the patient meets specific criteria, including imaging studies confirming neurocompressive findings or demonstration of significant radiculopathy findings in a specific distribution. The submitted MRI revealed no significant deficiencies in the cervical spine. No information was submitted regarding strength, reflex, or sensation deficits identified within the specific distributions. There is an indication on the MRI of a mild central canal stenosis at C6-7. However, no information and no clinical evaluation findings were indicated confirming C6 or C7 involvement. Without this information in place, it is the opinion of this reviewer that the requested EMG is not medically necessary. As such the prior denial is 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)