AccuReview

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[Date notice sent to all parties]: April 23, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 EMG of the XX XX XX, as Outpatient between XX and XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board certified in Orthopaedic Surgery with over 15 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

XX: Encounter dictated by XX XX, XX. Claimant is a very pleasant XX- year -old XX who comes into the office for a follow up evaluation, previously given XX XX prescription, reported XX has provided some stability. XX reported pain, but improved and increased pain with XX motion. PE: XX walking normal, but XX walking causes increased XX XX pain. Squatting and returning to XX is slow and painful. ESI XX ordered.

XX: Encounter dictated by XX XX, XX. PE: XX XX: Rotation to the XX (5 deg) and the XX (40 deg), XX (30 deg) and extension (30 deg), and XX XX normal. The claimant complains of immense pain with XX rotation. Assessment/Plan: TBI, prolapsed XX XX disc, compression fracture of XX XX, prolapsed XX XX disc XX-XX, Compression fracture of the XX XX XX and XX, Prolapsed XX XX disc, XX pain, XX XX, XX XX pain, XX XX pain, XX XX, XX.

XX: Encounter dictated by XX XX, XX. CC: none recorded. HPI: claimant is a XX-year old XX s/p a work-related accident on XX while XX was XX a XX on a XX XX XX. At the time of the accident, XX was on the XX when a XX of the XX from the

XX XX XX. XX immediately XX XX and XX to the XX. XX was taken to XX XX XX XX where XX was admitted for XX days. Assessment/Plan: 1. TBI. 2. XX XX Disc. MRI shows XX XX, XX, XX, XX. XX pain constant 7-8/10 constant, tension and stiffness, radiates down both XX and XX, noticed weakness and loss of strength of both XX, numbness and tingling on XX XX. Has trouble getting a XX XX because XX XX XX XX XX. Has trouble XX. Stated meds help pain, but XX gets XX when XX has no strength to XX simple XX XX. Plan CESI, XX XX EMG also ordered, pending approval. 3. Compression fracture of XX XX with XX. 4.0Compresion fracture of XX XX with XX. 5. XX and XX.

XX: Encounter dictated by XX XX, XX. CC: none recorded. PE: 1. TBI. 2. XX XX Disc. Claimant has noticed weakness and loss of strength of both XX, numbness and tingling on the XX XX. Has trouble getting a XX XX because XX can't find XX XX. Has trouble XX XX. Stated meds help XX pain but gets XX when XX has no strength to XX XX XX work. Plan for CESI. XX XX EMG has also been ordered, pending approval.

XX: Pre-op Orders dictated by XX XX, XX. DX: ICD-10: XX Radiculopathy, XX region. Orders: nerve conduction study/EMG, XX XX (PROC), note XX upper extremities.

XX: UR performed XX, XX. Reason for denial: It is unclear why there is a request for EMG testing of the XX XX. This claimant is not complaining of any neurological problems in the XX XX nor is there any abnormal neurological findings of the XX XX on physical examination. Accordingly, this request is not medically necessary.

XX: UR performed by XX, XX. Reason for denial: Understanding that the individual sustained a XX XX trauma to the XX, reportedly resulting in an episode of XX, the MRI of the XX XX notes multiple level XX changes as there are XX mm XX XX identified at XX separate levels. Furthermore, the physical examination did not identify any specific indicators that would suggest a nerve root compromise. There is no motor loss there is no XX XX, or any other presumptive findings suggested or a radiculopathy. Therefore, based on the clinical information presented for review tempered by the specific parameters identified in the ODG, there is no clear clinical indication presented to suggest the need for this electrodiagnostic assessment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld and agreed upon. The request for EMG of the XX XX XX is denied. This claimant sustained a work accident XX. XX currently has XX pain. XX reports weakness and loss of strength in both XX with numbness and tingling in the XX XX. XX XX XX MRI demonstrates multiple levels of XX XX disease with XX mm XX XX (XX through XX). The treating physician has recommended electrodiagnostic studies (EMG/NC) for further evaluation of XX XX. The Official Disability Guidelines (ODG) supports electromyography (EMG) in the diagnosis of XX XX. According to the records reviewed, this patient has no evidence of XX radiculopathy on examination. XX has no motor loss or sensory loss that would be consistent with nerve compression. Electrodiagnostic testing with EMG is not medically necessary for this patient. Therefore, after reviewing the medical records and documentation submitted, the request for XX EMG of the XX XX XX, as Outpatient between XX and XX is denied.

XX

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN 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 XX 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)**