

C-IRO, Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW:

JULY 20, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Somatosensory Study (95926) 1/15/2007

Nerve Conduction (95904) 1/15/2007

H Reflex Study (95934) 1/15/2007

Ultrasound (Pelvic 76856, Spinal 76800, Extremity76880) 1/15/2007

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

MD 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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Initial examination, Dr., 01/08/07

Notes, 01/10/07, 01/11/07 and 01/12/07

Dermatomal EP and motor sensory, 01/15/07

Musculoskeletal diagnostic ultrasound, 01/15/07

Request for hearing regarding the disputed services, 06/29/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who reported gradual onset of lumbar pain and left leg pain, numbness and tingling on xx/xx/xx not related to a specific event. He was evaluated by chiropractor Dr. on xx/xx/xx with findings of severe tenderness and spasm in the lumbar area as well as positive straight leg raise test, Minor's sign, maneuver and Kemp's test. A ruptured lumbar disc was diagnosed and treatment included temporary total disability work status, chiropractic adjustments, interferential current therapy, ultrasound, electro-muscular stimulation and flexion/distraction. The claimant received treatment on 01/10/07, 01/11/07 and 01/12/07. Dr. report on 01/12/07 noted new complaints of frequent urinary stream weakness. Dr. documented that the claimant had no saddle paresthesia or anal sphincter numbness and that the claimant reported being able to empty his bladder completely. Dr. documented the claimant's wish to continue chiropractic treatment and not be referred to a surgeon. On 01/15/07 nerve conduction study and somatosensory study was performed, the results of which were within normal limits. A musculoskeletal diagnostic ultrasound study, also on 01/15/07, reported the presence of facet area inflammation within the thoracic and lumbar spine.

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

The request for a sensory study does not appear to be medically necessary according to ODG guidelines. The claimant is a male who underwent a nerve conduction study on xx/xx/xx and a somatosensory study. A somatosensory study/surface EMG is not recommended per ODG guidelines, rather a needle EMG is recommended in the presence of objective symptoms of radiculopathy. Surface EMGs lack specificity and lack support for the key attributed for a diagnostic test. The Reviewer is unable to support the previously performed study based on the recommended ODG guidelines. Thus, the Reviewer agrees with the determination of the Insurance Carrier.

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 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

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates: Low Back
EMG:

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)