

# MEDICAL REVIEW OF TEXAS

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**DATE OF REVIEW:**           **JUNE 4, 2007**

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

EMG/NCV both lower extremities

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

MD, Board Certified

## **REVIEW OUTCOME**

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

- Upheld                           (Disagree)
- 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**

- non-authorizations of 5/4/07 and 4/18/07
- MD (4/24/07, 4/11/07)
- Letter from (5/22/07; [Low Back-Lumbar & Thoracic (Acute & Chronic)])

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A male injured on xx/xx/xx. Underwent lumbar fusion at L4-5 and L5-S1. On 9/30/05 he underwent hardware removal and re-exploration. There was resolution of left leg pain following surgery. Per Dr. letter of 4/24/07, the patient has undergone repeat low back surgery of uncertain type on 11/28/06 and it was after this surgery that the leg pain resolved. Subsequent to this surgery, the patient developed right lower extremity pain, which according to Dr. is “in the sciatic distribution”.

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

SINCE THIS NEW RIGHT LEG PAIN IS, ACCORIDNG TO HIS TREATING PHYSICIAN, IN THE SCIATIC DISTRIBUTION AND IS POST-OPERATIVE IN RELATION TO SURGERY FOR THE PATIENT’S WORKERS’ COMPENSATION COVERED INJURY, IT IS REASONABLE TO ASSUME THAT IT IS POSSIBLE THAT THERE COULD BE LUMBOSACRAL RADICULAR FINDINGS IN THE RIGHT LOWER EXTREMITY. THIS IS CERTAINLY CLINICALLY A POSSIBILITY POST-OPERATIVELY SINCE THESE RADICULAR SYMPTOMS BEGAN AFTER SURGERY.

THERE IS APPROVAL FOR EMG/NCV IN THE RIGHT LOWER EXTREMITY. THERE IS APPROVAL FOR EMG/NCV OF THE RIGHT LOWER EXTREMITY WITH BILATERAL H-REFLEX (WAVE) BUT NOT BILATERAL LOWER EXTREMITY EMG/NCV. THIS IS ALSO IN KEEPING WITH ODG-TWC INTEGRATED TREATMENT DISABILITY DURATION GUIDELINES FOR LOW BACK, LUMBAR, AND THORACIC DYSFUNCTION IN REGARD TO EMG AND IN KEEPING WITH WELL-ACCEPTED CLINICAL GUIDELINES AND MEDICAL LITERATURE.

**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
- 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)