



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 10/01/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral lower extremity EMG/NCV study

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

Board Certified in Neurology

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.

Bilateral lower extremity EMG/NCV study - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.C. dated 01/31/06, 10/20/06, 03/02/07, 04/02/07, 05/03/07, 06/04/07, and 07/06/07

X-rays of the lumbar spine interpreted by M.D. dated 02/06/06

An MRI of the lumbar spine interpreted by Dr. dated 03/22/06

Evaluations with P.A.-C. for M.D. dated 04/27/06, 06/06/06, and 08/09/06

Procedure notes from Mr. dated 06/20/06 and 07/27/06

Evaluations with P.A.-C. for D.O. dated 09/07/06, 01/05/07, 02/05/07, and 07/25/07

Procedure notes from Dr. dated 10/10/06, 11/06/06, and 12/04/06

Letters of non-authorization, according to the ODG, dated 05/25/07, 07/10/07, 08/13/07, and 08/31/07

A claim summary form dated 09/10/07

PATIENT CLINICAL HISTORY

On 01/31/06, Dr. recommended an MRI of the left shoulder, physical therapy, medication, a hot pack, and a lumbar brace. X-rays of the lumbar spine interpreted by Dr. on 02/06/06 were unremarkable. An MRI of the lumbar spine interpreted by Dr. on 03/22/06 revealed a disc herniation at L4-L5 with some desiccation. On 04/27/06 and 06/06/06, Mr. performed an unknown injection and recommended physical therapy and continued medications. Mr. performed further unknown injections on 06/20/06 and 07/27/06. On 08/09/06, Mr. recommended physical therapy. Lumbar epidural steroid injections (ESIs) were performed by Dr. on 10/10/06, 11/06/06, and 12/04/06. On 01/05/07, Dr. recommended a tennis elbow strap and physical therapy. On 03/02/07, Dr. recommended an orthopedic evaluation for the shoulder. On 05/03/07, Dr. recommended an EMG/NCV study of the lower extremity. On 05/25/07, 08/13/07, and 08/31/07, wrote letters of non-authorization for the EMG/NCV studies. On 06/04/07, Dr. recommended shoulder surgery. On 07/10/07, wrote a letter of non-authorization for a lumbar ESI.

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

The patient has received improvement after her lumbar injury with left L4-L5 radiculopathy. Her latest discal findings showed negative straight leg raising at 90 degrees without evidence of weakness, atrophy, or sensory loss. Therefore, based on ODG Treatment Guidelines, she does not require a bilateral lower extremity EMG/NCV study.

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 AND KNOWLEDGE BASE
- 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)