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IRO Certificate #

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 9/6/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat EMG/NCV Right and left lower extremity

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

M.D. Board Certified in Neurosurgery

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

Notification of Determination –8/2/07

Reconsideration Letter – 8/14/07

CT Scan Report– Lumbar with and without contrast – 1/16/06

Electrodiagnostic Test Report- 3/7/06

Radiology Report – Lumbar X-ray, 7/14/05

Progress Note – M.D. 11/8/05

Clinical Notes – D.C 7/12/05 – 7/25/07

Reference: ODG and ACOEM Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured while working. The details of that injury are not reported in the records received. Back pain primarily with right lower extremity discomfort developed and remained despite chiropractic treatments and rest. There is no history of previous difficulties being present before the injury. On examination there is no reflex sentry or motor deficit recorded. Lumbar MRIs in October of 2001 and October 2002 show L3-4 disc rupture primarily to the right side. There was some question of L4-5 disc trouble also and it was then recommended that the patient get an electromyography exam. Previous Electrodiagnostic testing in March of 2006 did not include electromyography. Clinical Notes made by the chiropractor in July 2007 indicates continued pain in the patients back and primarily right lower extremity and agreed with the recommendation for an EMG evaluation to come to conclusion regarding the location of the radiculopathy.

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

I disagree with the benefit company's decision to deny the requested Electrodiagnostic testing to include electromyography. When the patient had the previous Electrodiagnostic testing, for some reason, the Electromyography was not done and that is a test that is most significant in determining radiculopathy. "Sub clinical" evidence on EMG radiculopathy is frequently helpful in coming to conclusions as to which area needs to be dealt with either from a surgical standpoint or a less invasive technique in dealing with these problems.

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 JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES

**X 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)**