

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/21/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Electro-diagnostic testing performed on 06/18/07

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

The TMF physician reviewer is a board certified neurologist with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the electro-diagnostic studies performed on 06/18/07 were medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice to Utilization Review Agent of Assignment of IRO – 04/11/08
- Position statement– 04/15/08

- Employers First Report of Injury or Illness –
- Report of MRI of the lumbar spine – 06/11/07
- Report of nerve conduction study – 06/18/07
- History and Physical examination by Dr. – 07/03/07
- Report of Medical Evaluation – 06/27/07
- Information for requesting review by an IRO – 04/07/08
- Letter from Dr. – 04/03/08
- Request for Review by an IRO – 04/03/08
- Explanation of Benefits – 07/02/07
- Patient Information Confirmation Sheet Worker's Comp – 06/15/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury when she was standing on a stool, reaching up to put a box on a shelf when she felt a pull in her right hip muscle. This resulted in pain radiating from the right hip down the upper leg. An MRI of the lumbar spine revealed an annular disc bulge at L4-L5. On 06/18/07 the patient underwent electro diagnostic studies including an EMG/Nerve conduction study.

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

This patient presented with symptoms suggestive of lumbar radiculopathy. Her MRI showed abnormalities at L4-L5. As per ODG treatment guidelines, electromyography was indicated as this test was needed to confirm the condition or exclude it. Because the patient had complaints of tingling and numbness, the nerve conduction study was necessary to evaluate for the presence of peripheral neuropathy.

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)**