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Notice of Independent Review Decision

DATE OF REVIEW: 12/03/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral lower extremity EMG

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

Licensed 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 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Examination Evaluation, M.D., 11/05/07
- DWC-73, M.D., 01/28/08, 02/25/08
- Lumbar Myelogram/Post-Myelogram Lumbar CT/Sagittal and Coronal Reconstructions/X-rays of the Lumbar Spine, M.D., 02/06/08

- Texas Outpatient Non-Authorization Recommendation, 10/22/08
- Texas Outpatient Reconsideration Decision: Non-Authorization, 11/10/08
- Preauthorization Appeal, Dr. 10/29/08
- Adverse Determination, 11/10/08
- Notice to URA of Assignment of IRO, 11/13/08
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained an injury to her lower back when she was in an elevator and it fell to the first floor in a free fall. She received physical therapy, medications, psychotherapy, and cortisone injections. She also had a lumbar MRI and a myelogram/CT scan performed

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

Based on the limited records available at this time, an EMG nerve study would not be medically necessary. I would need a full documented history and physical examination by Dr. showing some evidence of a radiculopathy by history or physical examination with strength, reflexes, and sensory examinations, along with straight leg raising maneuvers, before I could justify the need for a needle EMG nerve study in view of the normal lumbar MRI scan and normal myelogram/CT scan showing only scoliosis and facet arthrosis.

This report is advisory in nature only and based solely upon the records available for review at the time of this dictation.

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)**