



# Lumetra

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## Notice of Independent Review Decision

**Date of Review:** 06-26-2008

**IRO CASE #:**

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

Office visit with EMG/NCV of right lower extremity

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

Certified by The American Board of Physical Medicine & Rehabilitation

### **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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.10	95860	Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Preauthorization Review Summary, 04-30-08

Peer review, 04-29-08

Preauthorization Review Summary, 05-20-08

Preauthorization Advisor (reconsideration) review, 05-20-08

Physician office notes, 02-07-08 and 04-01-08

Physician prescription for Right L/E EMG/NCS, 02-07-08

Official Disability Guidelines and Treatment Guidelines - Low Back

## **PATIENT CLINICAL HISTORY:**

The claimant is a xx-year-old male reported to have had a work-related back injury dating back to xx/xx. Sometime between xx/xx and April 2008 the claimant underwent physical therapy, received medications and a percutaneous discectomy. The surgical procedure apparently did not alleviate the symptoms. An MRI had been completed and electrodiagnostic testing was pending. A significant disc lesion was noted on MRI and prominent lower extremity symptoms were noted by the primary treating provider.

The request for electrodiagnostic studies was not authorized.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

In the opinion of the Reviewer, the requested office visit with EMG/NCS right lower extremity is not medically necessary for this claimant.

According to the Reviewer, ODG notes that this study might be helpful in certain circumstances. The progress reports fail to develop the clinical need for such a study. From the record, there is a disc lesion noted on MRI and there are changes noted on physical examination. However, there is no evidence of detailed documentation of objective clinical findings to substantiate the medical necessity of the office visit and electrodiagnostic studies in this case.

**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)