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Notice of Independent Review Decision

DATE OF REVIEW: 06/11/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV lower extremities and x-ray of lumbar spine

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

Board Certified in Orthopedics

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.

EMG/NCV lower extremities - Upheld
X-ray of lumbar spine - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on xx/xx/xx. He has undergone treatment with physical therapy, medications, injections, and CPMP. Current medications include Lyrica, Tramadol, Celebrex, Altace, and Ibuprofen.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE

CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The electrodiagnostics of the spine are neither reasonable, nor medically necessary. The patient appeared to have left foraminal stenosis on his MRI and his physical examination confirms radiculopathy in that area. Electrodiagnostic studies, such as an EMG/NCV, are not necessary. The diagnosis is clear. The patient does not have any complicating factors such as neuropathy or diabetes. The electrodiagnostic studies will not add any diagnostic information and therefore should not be performed.

The lumbar dynamic views (flexion/extension views) are neither reasonable, nor necessary at this time. The patient does not appear to have any spondylolisthesis or other instability noted on the plain films. The patient is not a surgical candidate. If surgery had been recommended and the differential was between the decompression and the decompression and fusion, then and only then would flexion/extension views have been reasonable or necessary.

Criteria for decision are derived from the *ODG* and the textbook *The Spine*.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area, as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines, and peer consensus.

This review should not be used in violation of TDI-Division of Workers' Compensation rules or orders nor used to deny previously preauthorized care. The opinions rendered in this case are the opinions of the reviewer. The review has been conducted without a medical examination of the individual reviewed. The review is based on documents provided with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/reconsideration may be requested. Such information may or may not change the opinions rendered in this report. This report is a clinical assessment of documentation and the opinions are based on the information available. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

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)