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**DATE OF REVIEW** 2/27/09

**IRO CASE #:**

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

EMG/NCS

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

Board Certified in Neurological Surgery

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> 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**

Adverse determination letters 1/8/09, 12/15/08  
Peer review, Dr. 1/5/03  
Peer review, Dr. 12/11/08  
11/24/08 report, Dr.  
3/6/08 PT report, MPT  
Neuro consultation report Dr., 1/15/08  
Chiropractic reports 2006-2007  
2/13/07, 11/24/08 reports Dr.  
IME Report Dr, 3/28/08  
Pain Management report 3/19/08, Dr.  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a xx year-old female who in xxxx had a twisting injury to her back and developed immediate pain in her low back that soon was join by tingling in both lower extremities. She had physical therapy and chiropractic treatments without significant benefit. AN MRI of the lumbar spine is reported to have shown an L4-5 disk rupture, but the radiology report was not provided for this review. The patient performed light duty at work for four years following the injury, but she has been unable to work to any significant extent since that time.

Her pain continues and varies considerably as to the exact locations, with even one lower extremity being involved at times as opposed to the other. The rather definite disk rupture diagnosis by MRI by one evaluator was not followed by any surgical procedure, so I must assume that the changes were minimal and not surgically significant. Electrodiagnostic testing has been recommended. There is no note by the person requesting the testing in the records provided for this review that indicates a reason for that testing.

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

I agree with the denial of the requested electrodiagnostic testing consisting of EMG and nerve conduction studies. There is nothing in the records provided that would suggest a particular location for evaluation, or results that would lead to a therapeutic approach to the problem.

**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)