



Lumetra

Brighter insights. Better healthcare.

One Sansome Street, Suite 600
San Francisco, CA 94104-4448

415.677.2000 Phone
415.677.2195 Fax
www.lumetra.com

Notice of Independent Review Decision

DATE OF REVIEW: 3/12/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV of the lower extremities

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

Certified by the American Board of Orthopedic Surgery and fellowship-trained in surgery of the spine

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination 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		95861 95903 95904 95900	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 6/23/08, 6/5/08

MRI report dated 3/18/08

Official Disability Guidelines cited Low Back-Procedure Summary EMG/NCS

PATIENT CLINICAL HISTORY:

This claimant sustained a low back injury on xx/xx/xx while lifting a bag of concrete. Treatment has included pain medication and Motrin. Physician notes that the claimant is having persistent low back pain radiating to the posterior aspect of the right lower extremity.

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

In the Reviewer's opinion, the requested procedure should be authorized as requested. The Reviewer noted that this claimant does have combination instability and facet arthrosis syndrome at L4-S1, which has resulted in a disc herniation. The claimant also has evidence of lumbar radiculopathy and neurological changes including motor and sensory changes. The Reviewer also noted that the claimant has failed all appropriate conservative care. Therefore, the proposed EMG/NCV evaluation is appropriate for this claimant.

In conclusion, this claimant's clinical course and history (appropriate conservative care and pain for 18 months that has interfered with his sleep and caused personality changes) qualifies this claimant for the requested procedure pursuant to the Official Disability Guidelines.

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)**