Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 12, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed EMG/NCV bilateral lower extremity with CPT codes 95900-6 units, 95903-4 units, 95860, 95904, 95934 and 95861

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

This case was reviewed by a Chiropractor with an unrestricted license to practice in the state of Texas. The Chiropractor is in active practice and is familiar with the treatment or proposed treatment. Diplomate, American Academy of Pain Management; Diplomate, American Board of Quality Assurance and Utilization Review Physicians; Certified in Healthcare Quality Management; Board Certified in Acupuncture (NBCE.)

REVIEW OUTCOME

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

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.73	95860, 95904, 95934, 95861		Prosp	1					Upheld
722.73	95900		Prosp	6					Upheld
722.73	95903		Prosp	4					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-15 pages

Respondent records- a total of 43 pages of records received to include but not limited to: letter 3.23.10, 3.8.10, 2.16.10; TDI letter 3.22.10; IRo request forms; report 2.16.10, 3.8.10; Testing, Inc preauth 2.1.10-2.11.10; MRI Lumbar 1.24.09, x-ray Lumbar 1.8.09; Healthcare notes 1.29.10-2.23.10; report 12.14.09

Requestor records- a total of 46 pages of records received from the patient to include but not limited to: MRI Lumbar 1.24.09; Spine specialists notes 3.1.10-3.2.10; patient letters 1.25.10, 2.3.10; email to 9.23.08; personal health records 5.18.08-11.13.08; ESI Lumbar reports 1.24.09-8.5.09; Lumbar x-rays 1.8.09; Dr. note 9.18.08; email to 9.17.08; DWC form 41; account statement; Dr. report 1.23.09-3.4.09; hip burstis; 12.14.09; TDI letter 3.22.10; letter 4.2.10

Requestor records- a total of 83 pages of records received from Dr. to include but not limited to: Healthcare records 1.25.10-3.17.10; patient letters 1.27.10; email to 9.23.08; personal health records 5.18.08-11.13.08; Therapy notes 10.20.08-11.20.08; email to 11.11.08; report, Dr. 8.18.08; FCE 2.2.10; ESI Lumbar reports 1.24.09-8.5.09; Lumbar x-rays 1.8.09; Functions Analysis; Dr. report 8.6.09-2.3.10; report, Dr. 1.23.09-3.4.09; Dr. 10.31.06; pharmacy receipts; email to 11.4.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an on the job injury on xx/xx/xx in which he twisted his lower back.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

I have not been able to determine the medical necessity of this request due to evidence-based guidelines. According to the Official Disability Guidelines regarding EMG and NCV, it states that EMGs are not necessary if radiculopathy is already clinically obvious. Regarding NCVs, the guidelines state that they are not recommended if the radiculopathy is already clinical obvious. An EMG would be to determine unequivocal evidence of radiculopathy. In this case, the findings are supportive of many different conditions but not specifically a neurologic deficit or sensory, motor, and deep tendon reflexes that would support the need for an EMG (i.e. neurologic deficit showing any type of radiculopathy or equivocation). It also states that this to be performed after one month clinical trial. The patient's condition dates back to 2006, and it would be of question as to whether or not this kind of testing has already been done. There is also a question of how this type of test would change the chiropractic treatment or the chiropractic treatment plan or outcome of chiropractic treatment in this case. At this time, it has not been determined that a bilateral lower extremity testing be performed as well, although the sensory findings over three different dermatomes were on the right and most of the provocative testing was bilateral.

Official Disability Guidelines, Low Back Injuries Chapter, version 3/26/10 states:

EMGs (electromyography)	Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are

	not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended.

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

XX 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)