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**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 07/23/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat bilateral lower extremity EMG/NCV study

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

Board Certified in Neurology

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.

Repeat bilateral lower extremity EMG/NCV study - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A lumbar myelogram CT scan interpreted by, M.D. dated 01/04/07
Evaluations with Dr. (no credentials were listed) dated 11/03/09, 05/04/10,
Preauthorization requests from M.D. dated 05/19/10 and 05/26/10
A letter of non-authorization, according to the Official Disability Guidelines (ODG), from D.O. dated 05/25/10
A letter of non-authorization, according to the ODG, from M.D. dated 06/03/10
An evaluation with (no credentials were listed) dated 06/11/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

A lumbar myelogram CT scan interpreted by Dr. on 01/04/07 showed suspected postsurgical changes at L3-L4 and L4-L5, small extra filling defects at L2-L3 and

L3-L4, and degenerative changes of the lower spine. On 05/04/10, Dr. recommended an EMG of the lower extremities. On 05/19/10 and 05/26/10, Dr. provided preauthorization requests for the EMG/NCV study. On 05/25/10, Dr. wrote a letter of non-certification for the EMG/NCV study. On 06/03/10, Dr. also wrote a letter of non-certification for the EMG/NCV study. On 06/11/10, Ms. felt an EMG/NCV study was not medically necessary at that time and that the patient needed to undergo a physical examination first.

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

The last physical examination performed documented normal strength, normal reflexes, normal sensation, and negative bilateral straight leg reflexes. An EMG is not indicated for low back pain alone. The patient has no documented evidence of any radicular symptoms or any radicular physical findings. Therefore, I would agree with the previous adverse determinations that the repeat bilateral lower extremity EMG/NCV study is not medically indicated or supported by the medical documentation provided nor is it inline with the ODG recommendations. The previous adverse determinations should be upheld in my opinion.

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 AND KNOWLEDGE BASE
- 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)