

SENT VIA EMAIL OR FAX ON  
Dec/14/2010

## True Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (214) 717-4260  
Fax: (214) 276-1904  
Email: rm@trueresolutionsinc.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Dec/13/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Lower Extremity NCS/EMG

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

AADEP Certified  
Whole Person Certified  
Certified Electrodiagnostic Practitioner  
Member of the American of Clinical Neurophysiology  
Clinical practice 10+ years in Chiropractic WC WH Therapy  
Chiropractor

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 11/11/10 and 11/22/10  
Dr. 10/15/10 thru 11/24/10  
Center 10/13/10 and 11/11/10  
Lumbar MRI W/O 10/18/10

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee was involved in an occupational injury on xx/xx/xx. The injured employee was standing on a bumper of a van trying to unload a ladder when he felt a pop

and pain in his low back. He was transported to Clinic where he was prescribed medication. He performed a change of treating doctor and fell under the care of Dr.. MRI of the lumbar spine dated 10/18/2010 revealed a 5.83mm disc herniation at L4-5 and 6.23mm disc herniation at L5-S1, thecal impingement and canal narrowing, the L4-5 disc is left paracentral. The injured worker was referred to Dr. MD for pain management evaluation and recommendations were made for an EMG/NCV to help diagnosis specific nerve irritation and direct the medical need for epidural injections. The treating physician is now requesting an EMG/NCV of the lower extremity is now being requested at this time.

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

The injured employee currently does meet the required guidelines for an EMG/NCV at this time. Documentation reviewed does support the request for EMG/NCV study of the lower extremity. Records reviewed revealed an MRI of the lumbar spine indicating two (2) disc herniations with thecal sac impingement and canal narrowing, which the MRI does not clearly indicate that IVF narrowing or radiculopathy. Examination findings revealed deficit left L5 sensory via sensory testing, which does not clearly indicate radiculopathy.

The ODG & American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain; however, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

Therefore in view of all the documentation submitted and ODG the requested services, EMG/NCV of the lower extremities would be considered medically necessary.

**ODG Criteria for the use of Epidural steroid injections:**

*Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.*

1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or **electrodiagnostic testing**.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)