

SENT VIA EMAIL OR FAX ON
Jan/11/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/11/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCV Lower Extremities

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

Chiropractor

Certified

Person Certified

TWCC ADL Doctor

Certified Electrodiagnostic Practitioner

Member of the American of Clinical Neurophysiology

Clinical practice 10+ years in Chiropractic WC WH Therapy

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 11/13/09 and 12/14/09

Dr. 9/10/09 thru 12/1/09

MRI 11/12/09

Dr. 12/15/09

PATIENT CLINICAL HISTORY SUMMARY

The injured employee was involved in an occupational injury on xx/xx/xx. The injured employee was apparently lifting a log with a co-worker when he injured his back. The injured employee reported the injury. He underwent therapy, FCE, and an MRI of the lumbar spine. He was seen by a DDE on 12-15-2009, who indicated that the injured employee was at MMI on 12-15-2009 and assessed him with a 5% WBI. Designated doctor indicated palpable tenderness at the L4-5, normal SLR, normal DTR, normal muscle strength, and decreased ROM in the lumbar spine. Request for EMG/NCV of the lower indicated hamstring and quadriceps motor 4/5 and right leg has increase in radiation after injury. 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 not support EMG/NCV study at this time in view of an essentially completely negative DD exam. Additionally EMG/NCV request from Dr. DC reported a positive right SLR and right side radiation. Records failed to indicate that is being radiated to the right side as well as no abnormal findings of motor or sensory defects.

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)