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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: July 29, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV studies of the bilateral lower extremities.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

The requested EMG/NCV studies of the bilateral lower extremities are not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/6/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/7/10.
3. Notice to IRO of Case Assignment dated 7/8/10.
4. Texas Workers' Compensation Work Status Report dated 6/29/09, 7/23/09, 8/6/09, 9/8/09, 11/3/09, 3/9/10, 3/12/10, 3/16/10, 3/30/10, 4/28/10, 5/26/10, 5/27/10, and 7/1/10.
5. Medical records dated 6/26/09 through 7/1/10.

6. Letter from Law Offices of dated 7/13/10.
7. Denial documentation dated 6/8/10, 6/22/10, 6/24/10 and 6/29/10.
8. ODG – TWC, ODG Treatment Integrated Treatment/Disability Duration Guidelines: Pain (Chronic).
9. ODG – TWC, ODG Treatment Integrated Treatment/Disability Duration Guidelines: Low Back – Lumbar & Thoracic (Acute & Chronic).

PATIENT CLINICAL HISTORY [SUMMARY]:

A review of the medical records indicates this female patient sustained an on-the-job injury on x/x/xx. A treatment note appears to indicate "contused shin." When the patient failed conservative treatment, she was referred to an orthopedic surgeon and he performed subacromial decompression and release of coracoacromial ligament. There was also a note on follow-up that diagnosed thoracic or lumbosacral neuritis on 5/27/10 and the patient complained of right leg numbness in addition to her right shoulder pain. EMG and NCV studies of the lower extremities have been requested. The patient was seen again on 7/1/10. On this date, her provider noted that the patient stated that her right shoulder hurts from time to time and therapy is helping. The provider also indicated that the patient reported her right shin sometimes hurts and the pain radiates down her right foot. The patient further reported that the pain was exacerbated by standing for long periods. Upon examination, neurological findings were normal. The provider's impression was right leg numbness. The patient is seeking authorization for EMG and NCV studies of the lower extremities.

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

The submitted medical records do not support the need for bilateral lower extremity EMG/NCS studies for this injury. The patient's initial injury occurred on 6/3/09. From that date until 5/27/10, there is no documentation of any reports of low back pain, lower extremity pain or lower extremity numbness in any of the patient's medical encounters. The report of an injury 11+ months after the initial injury exceeds the Division of Workers Compensation guidelines (DWC) which require that the injury be reported within 30 days of the occurrence. Additionally, the Official Disability Guidelines (ODG) do not apply because the compensable body areas of injury were not established to include the low back and/or radiculopathy. All told, the request for bilateral lower extremity EMG/NCS is not a reasonable benefit for the medical management and treatment of the 6/3/09 injury, and therefore this service is not medically necessary.

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

[X] DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] 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)