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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 07/14/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV study of the bilateral extremities

**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.

EMG/NCV study of the bilateral extremities Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

X-rays of the lumbar and thoracic spine interpreted by Dr. on xxxx showed minor degenerative changes at L5-S1 and lower thoracic levels. On 09/09/04,

Dr. noted the patient had a history of neck, thoracic, and low back pain for the past several years. An MRI of the lumbar spine interpreted by Dr. on 09/29/04 showed a 1 mm. disc protrusion at L2-L3 and a 2 mm. disc protrusion at L4-L5 with annular tear and mild bilateral foraminal narrowing. An MRI of the cervical spine interpreted by Dr. on 09/29/04 showed 0.5 mm. protrusions at C2-C3 and C3-C4, a 1 mm. posterior protrusion at C5-C6, and a 1.5 mm. protrusion at C6-C7. An MRI of the thoracic spine interpreted by Dr. on 09/29/04 was unremarkable. Lumbar epidural steroid injections (ESIs) were performed by Dr. on 10/06/04, 10/20/04, and 12/20/04. Physical therapy was performed with Mr. on 10/19/04 and 10/22/04. Physical therapy was performed with an unknown therapist from 09/27/05 through 10/25/05 for a total of six sessions. An MRI of the lumbar spine interpreted by Dr. on 12/13/05 showed mild protrusions at L3 through S1. An MRI of the right hip interpreted by Dr. on 11/16/06 was unremarkable. X-rays of the lumbar spine, pelvis, and right shoulder interpreted by Dr. on 01/22/07 showed lumbosacral facet arthrosis bilaterally and cystic changes at the distal clavicle at the AC joint. CT scans of the lumbar spine and SI joints interpreted by Dr. on 01/25/07 showed a left paracentral 4 mm. herniated disc at L4-L5 and bilateral facet arthropathy at L5-S1 and mild osteoarthritic changes of the SI joints with early vacuum phenomenon on the left. An MRI of the right shoulder interpreted by Dr. on 02/02/07 showed degenerative changes of the AC joint, minimal joint effusion, and minimal bone marrow edema. A right shoulder injection was performed by Dr. on 02/13/07. Bilateral SI joint injections were performed by Dr. on 02/26/07. On 04/11/07, Dr. placed the patient at clinical Maximum Medical Improvement (MMI) with a 10% whole person impairment rating. On 04/25/07, Dr. felt the impairment rating was wrong and requested clarification. On 06/21/07, Dr. amended his report with MMI as of 04/11/07 with a 5% whole person impairment rating. An EMG/NCV study interpreted by Dr. on 12/04/07 showed evidence of bilateral L5-S1 radiculopathy. On 12/05/07, xxxx wrote a letter of non-authorization for bilateral facet injections, according to the ODG. On 12/31/07, xxxx wrote a letter of authorization for a right SI joint injection, which was performed by Dr. on 01/14/08. On 06/25/08, 12/31/08, and 04/06/09, xxxx wrote letters of authorization for bilateral SI joint injections, which were performed on 07/01/08, 01/05/09, and 04/08/09. On 09/17/09, xxxx wrote a letter of non-authorization for bilateral SI joint injections. On 04/20/10, Dr. recommended an orthopedic evaluation and another SI joint injection. On 05/04/10, xxxx rendered no decision regarding bilateral SI joint injections. On 06/02/10 and 06/23/10, xxxx wrote letters of non-authorization, according to the ODG, for an EMG/NCV study of the bilateral lower extremities. On 06/14/10, the patient wrote a letter of appeal for an MRI of the lumbar spine, EMG/NCV study of the lower extremities, bone scan, and non-invasive vascular studies of the arterial bilateral legs.

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

After reviewing the medical records provided, the patient does not require a repeat EMG/NCV study of the bilateral lower extremities. The patient has had a previous EMG/NCV study on 12/04/07 read by Dr. showing a possible bilateral

L5-S1 radiculopathy. She has had a Designated Doctor Examination on 04/11/07 showing a completely normal physical examination neurologically with normal reflexes, motor examination, and sensory examination with negative bilateral straight leg raising. He felt she had a lumbar sprain/strain syndrome.

Based on the records available for review and using the Official Disability Guidelines (ODG), in which an EMG/NCV study may be useful to obtain unequivocal evidence of radiculopathy, this patient does not meet that requirement as she does not have any clinical signs of radiculopathy by history or by physical examination. Therefore, from a clinical standpoint, diagnostic studies involving an EMG/NCV study of the bilateral lower extremities would not be indicated or warranted based on her subjective symptoms alone, as there are no physical findings supporting the diagnosis of radiculopathy. Therefore, in my opinion, the previous adverse determinations should be upheld.

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)