

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Needle EMG/NCV for bilateral lower extremities (95861; 95903 x 2; 95903 x 4; 95934 x 2)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Neurologist

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

Denial Letters, 5/19/10, 6/2/10
Exam Notes, 5/19/10, 6/1/10
Medical Group 5/10/10, 1/8/09
Pain Center 3/23/10
5/7/10, 3/26/10
ODG Low Back Chapter

PATIENT CLINICAL HISTORY SUMMARY

On xx/xx/xx, this patient injured his low back at work. Following fusion surgery, he has continued with back pain that radiates to the right lower extremity. Neurological exam showed no weakness in lower extremities. An MRI showed L5-S1 right paracentral disk protrusion with nerve root impingement of L5 and S1 roots bilaterally. The patient is on narcotic medications. He ambulates with a cane.

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

This patient has continuing low back pain. It is not clear from the record that any cause other than "radiculopathy" has been considered. No history was obtained as to the details about exacerbating and relieving factors. No detailed examination of the back is present. Reflexes, sensory examination, straight leg raise, quantitative range of motion of the back are not recorded. The only description of gait is that he walked with a cane. No history of exacerbating or relieving factors of the pain is recorded. It is unclear if there are psychiatric problems or malingering present. It is unclear if Waddell's signs are present. There is no information in the records about activity level, sleep habits or nutrition. The guidelines in ODG

Low Back Chapter for EMGs are not satisfied. The ODG does not recommend Nerve Conduction Studies. The reviewer finds that medical necessity does not exist for Repeat Needle EMG/NCV for bilateral lower extremities (95861; 95903 x 2; 95903 x 4; 95934 x 2).

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)