



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

05/13/2010

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 05/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCS bilateral upper & lower extremities

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

Texas State Licensed DO Board Certified Physical Medicine & Rehab physician

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment 04/26/2010
2. Notice of assignment to URA 04/26/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 04/09/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 04/09/2010
6. letter 03/31/2010, 03/02/2010
7. Medical note 12/03/2009, 10/07/2009, 10/05/2009, 09/16/2009, 07/29/2009, 07/22/2009, 07/08/2009, 06/24/2009, 06/10/2009, 05/27/2009, 05/13/2009, 05/06/2009, 04/28/2009,
8. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

This female sustained an occupational slip and fall lower back injury of xx/xx/xx. As a result of this injury she complains of low back pain and bilateral lower extremity radicular pain. A more recent complaint is that of right hand "numbness." Examination findings of the claimant demonstrate no upper or lower extremity focal neurologic impairment. The claimant underwent



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a non-contrast lumbar MRI scan demonstrating congenital lumbar spinal stenosis to a mild degree at L3-4, L4-5, and L5-S1 levels. There is left greater than right annular fibrosis bulging at the L4-5 level with displacement of the left L4 dorsal root ganglion. The review request is for EMG/NCS bilateral upper & lower extremities.

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

The decision for the requested EMG/NCS of bilateral upper and lower extremities is upheld. The request does not satisfy ODG criteria for electrodiagnostic testing. The claimant demonstrates no documented physical examination findings of an upper or lower extremity neurologic impairment to medically justify this request; therefore, the decision is 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 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)