



Notice of Independent Review Decision

DATE OF REVIEW: 08/11/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV Bilateral Lower Extremities

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

Board Certified in Physical Medicine & Rehabilitation

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 Bilateral Lower Extremities – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Evaluation, Health Centers, 05/26/11
- Prescription, D.O., 05/26/11
- Evaluation, Dr. 06/02/11, 07/15/11
- Pre-Certification Request, M.D., 06/06/11
- Correspondence, Dr., Undated
- Denial Letters, 06/09/11, 06/29/11
- The ODG Guidelines were provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The clinical notes submitted for review are handwritten in nature. The records indicate the patient tripped over a cord on the date of injury. A handwritten document from Health Services dated xx/xx/xx indicated that the patient was with symptoms of pain in the left lower extremity. The report did not appear to reveal any findings worrisome for a neurological deficit on physical examination. It was documented that the patient was on the following prescriptive medications: Ibuprofen and Vicodin.

A medical re-evaluation occurred at Health Services on 06/02/11 at which time it was noted that the patient had previously been recommended for treatment in the form of physical therapy, although the patient had not yet committed to such treatment. It was recommended that the patient receive access to treatment in the form of physical therapy services and additionally, it was recommended that an electrodiagnostic assessment be accomplished.

A physician re-evaluation occurred at Health Services on 07/15/11. It was noted that the patient wanted to pursue physical therapy at a facility called. The report did not describe the presence of a focal neurological deficit on physical examination.

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

Based on the records available for review, the Official Disability Guidelines would not presently support a medical necessity for a diagnostic study in the form of an electrodiagnostic assessment of the lower extremities. This specific reference would not support this specific request to be of medical necessity when there is no documentation of a focal neurological deficit in the lower extremities. Additionally, there are no symptoms referable to the right lower extremity. The handwritten notes available for review discuss symptoms of primarily pain in the left lower extremity. The above-noted reference does not support a medical necessity for an electrodiagnostic assessment if there are obvious signs of a radiculopathy. The records available for review document that there are symptoms of left-sided sciatica. Thus, based on the records presently submitted for review, medical necessity for a bilateral lower extremity electrodiagnostic assessment would not be supported per criteria set forth by the Official Disability Guidelines. The

submitted clinical documentation for review does not fulfill appropriate criteria per the above-noted reference to support this specific request to be one of medical necessity.

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)
- AMA GUIDES 5TH EDITION