



Medwork Independent Review

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

DATE OF REVIEW: 02/25/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV bilateral lower extremities (95904, 95934, 95861, 95869, 95870, 95900)

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

Texas State Licensed Doctor of Chiropractic

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 to Medwork 02/07/2011
2. Notice of assignment to URA 02/07/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 02/01/2011
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 02/01/2011
6. letter 02/04/2011, 01/24/2011, peer review 01/23/2011, letter 01/07/2011, peer review 01/06/2011, medicals 11/30/2010, MRI 06/30/2010, referral
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient had an on the job injury date of xx/xx/xx. She injured the neck and back while lifting a rug which weighed around 25-30 pounds. She was lifting it to a top shelf, when the rug fell, striking the claimant on the chest. Records state the patient was reporting radiating pain into both lower extremities. The provider does not note abnormal deep tendon reflexes, does not note a positive Valsalva sign, does not report positive straight leg raises / root tension signs, decrease in girth of lower extremity muscles, sensitivity changes, or other objective signs of possible radiculopathy. MRI of the L-spine was performed. The radiological report disclosed a diffuse bulge at L1-L2, broad based disc with facet arthropathy and moderate canal stenosis at L4-5, and at the lumbosacral interval, a small central disc protrusion around 2 millimeters which did not cause cord displacement, nor impinge on nerve roots. The claimant was examined by a



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Designated Doctor, report says that the patient was at a point of clinical MMI, and awarded her a 5% whole body impairment rating. There was mention of a request for a neuromuscular stimulator, and there were further evaluations at a local medical clinic. On 11/04/2010, a peer review concluded further care from the provider was not needed. On November 30, 2010, the claimant changed treating doctors and complained of lumbar pain. Review request is for EMG/NCV bilateral lower extremities (95904, 95934, 95861, 95869, 95870, 95900).

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

After considering the documents reviewed, the records have failed to demonstrate proper criteria for the requested EMG/NCV bilateral lower extremities (95904, 95934, 95861, 95869, 95870, 95900) and failed to meet the standards established in the Official Disability Guidelines; therefore, the insurer's decision to deny the requested is upheld. The Official Disability Guidelines for EMG with regard to the low back says, "Recommended as an option (needle, not surface) EMG's (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month of conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious." With regard to the NCV, (nerve conduction velocity) portion of the request, the Official Disability Guidelines says, "Not recommended. There is minimal justification for performing nerve conduction velocities when a patient is presumed to have symptoms on the basis of radiculopathy." The review records failed to establish, through objective criteria, that there exists any of the normal objective clinical signs which support the suggestion of radiculopathy such as root tension signs, deep tendon reflex changes (reported as normal), signs of decrease in muscle girth size, etc..

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 KNOWLEDGBASE
- 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



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- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**