

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/16/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
EMG/NCV of the bilateral lower extremities

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

MD, Board Certified Family Practice  
American Board of Family Medicine

**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**

Official Disability Guidelines, Low Back Chapter  
Treatment notes 2/10/11-4/20/11  
Request to change treating provider 2/1/11  
Preauthorization request 3/7/11  
WC Verification 2/23/11  
Medical Record review 6/12/2007  
Medical Records review 5/2/2005  
Preauthorization determination and notice 3/10/11  
Request for authorization 3/24/11  
Patient referral 3/23/11  
Preauthorization determination and notice 3/31/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male who sustained an injury to the back on xx/xx/xx. Initial diagnosis was lumbosacral sprain and he was treated conservatively with medications, physical therapy and chiropractic care. Initially the patient was determined to not be a surgical candidate however sought second opinion and was taken to surgery in 1993 followed by postoperative care. He was placed at MMI in 1994. There was then a gap in treatment until 1996 and again until 2005. Peer review completed in 2005 determined there were insufficient records to render an opinion of medical necessity. A subsequent peer review in 2007 also stated there was insufficient data and recommended the patient be seen for workup. In 2/2011 the patient is noted as having been seen for lumbar pain radiating into the lower extremities. The patient reported that until 1/2011 he had been doing fine until his back became stiff. Diagnosis was post-laminectomy syndrome and chronic low back pain. Medications included Lortab and Soma. Physical examination revealed decreased range of motion of the lumbar spine. Also noted was decreased strength and sensation in the lower extremities. The patient was subsequently recommended to undergo EMV/NCV of the lower extremities. An initial review was completed on 3/10/11. Request was denied for lack of information to include

conservative treatment history and information regarding specific pattern of involvement that would establish need to determine specific symptom generator. The denial was upheld on appeal on 3/31/11. The reviewer noted no indication of an onset of new symptoms and lack of documentation to include prior study results. Subsequent to the request for authorizations the patient was seen for follow up on 4/20/11. It was noted that the requests for EMG/NCV had been denied. The notes are somewhat illegible but appear to indicate a neurological evaluation was also denied and orthopedic/pain management had refused to see the patient.

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

There is a lack of clinical information to support medical necessity for this request. Moreover the patient indicated until 1/2011 he was doing fine until his back became stiff. There is no indication of a new injury. There is also no indication of follow up during the long gap in treatment. Given his treatment and surgical history it is likely that he has previously undergone electro diagnostic studies. These are not provided for review. There is also no indication if this is a new onset or if he has previously had these symptoms. In addition, the ODG recommends electrodiagnostic studies to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but also states EMGs are not necessary if radiculopathy is already clinically obvious. There is no indication in the records provided the patient meets either of these conditions and as such medical necessity is not established. The reviewer finds there is no medical necessity at this time for EMG/NCV of the bilateral lower extremities.

**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)