

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 10/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV of the lower extremities as an outpatient

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

The TMF physician reviewer is board certified in neurology with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the EMG/NCV of the lower extremities as an outpatient is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 10/04/11
- Notice of Denial of Pre-authorization from – 08/22/11
- Notice of Reconsideration from – 09/06/11
- Physician review by Dr. for – 08/16/11
- Report of MRI of the lumbar spine – 01/20/11

- Referral to United Neurology – no date
- Notification of Determination from – 08/18/11
- Physician review by Dr. for – 08/31/11
- Preauthorization request from Dr. – 05/13/11
- Letter of medical necessity by Dr. – 08/24/11
- Office visit notes by Dr. – 08/23/11
- Office visit notes by Dr. – no date
- Orders from Dr. for continued PT, EMG, ESI and anti-inflammatory medications – 06/20/11
- Office visit notes by Dr.– 06/20/11
- Report of functional capacity evaluation - 06/08/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when some metal from above him landed on him. This resulted in injury to his low back and right knee. The right knee was lacerated and resulted in stitches. The patient continues to complain of increased pain in the lower back radiating into his left thigh. There is a request for an EMG/NCS of the lower extremities for further evaluation.

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

The EMG/NCV testing is not clinically necessary. It will not alter any clinical care of this patient since his examination is non-focal for an objective perceptible, which is consistent with his MRI that indicated “no nerve root compression. The testing will not and should not alter his subsequent care.

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)

Electrodiagnosis in Diseases of Nerve and Muscle, 3rd edition, Jun Kamura, 2001, Oxford Univ-Press