

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 04/24/12

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

EMG/NCS of upper and lower extremities (95903, 95904, 95934, 95861)

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.C., Diplomate, Congress of Chiropractic Consultants

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
338.2	95903		Prosp.		03/23/12 – 04/03/12		06/30/91	359468	Overturn
338.2	95904		Prosp.		03/23/12 – 04/03/12		06/30/91	359468	Overturn
338.2	95934		Prosp.		03/23/12 – 04/03/12		06/30/91	359468	Overturn
338.2	95861		Prosp.		03/23/12 – 04/03/12		06/30/91	359468	Overturn

**INFORMATION PROVIDED FOR REVIEW:**

1. Certification of independence of the reviewer and case assignment.
2. TDI case assignment.
3. Letters of denial 03/23/12 & 04/03/11, including criteria used in the denial.
4. Podiatric office visit notes 01/23/12 & 04/14/11.
5. Electrodiagnostic evaluation 01/30/12.

6. Preauthorization request 01/30/12, preauthorization request for reconsideration 03/27/12, MDR/IRO preauthorization supplement #1 04/04/12.

**SUMMARY OF INJURED WORKER'S CLINICAL HISTORY:**

The records indicate the patient suffered a work-related injury on 06/30/91. Specifics were not provided as to all of the compensable areas, or as to all treatment that has been rendered in the past. It is obvious he has had various treatments over the years, as well as previous diagnostic testing. The records indicate he has neurological/sensory deficits and motor deficits both subjectively as well as clinically, documented via objective findings.

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

ODG Guidelines clearly allow for electrodiagnostic testing. There are portions in the Guidelines where mention is made that testing may not be necessary if radiculopathy is confirmed clinically. In this case, it is not definitely clinically confirmed. Also, the testing has been suggested to confirm a brachial plexus abnormality or some other problem other than radiculopathy.

The request for the treatment in dispute does meet the required ODG Guidelines criteria. The new treating doctor needs the electrodiagnostic testing results to allow him to properly assess this patient's current condition some eleven (11) years post injury.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THIS 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 judgment, 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 national accepted medical literature:
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)