

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/03/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCV bilateral LE

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

M.D., Board Certified Orthopedic spine surgeon, practicing neurosurgeon

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)

The reviewer finds EMG bilateral LE is medically necessary. The reviewer finds NCV bilateral LE is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines

Request for IRO 03/15/12

Utilization review determination 02/22/12

Utilization review determination 03/05/12

Clinical records Dr. 02/01/12

Clinical note Dr. 12/22/11 and 01/03/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who developed low back pain while picking up metal beams and crates on xx/xx/xx.

On 12/22/11, an office visit with Dr. documented low back pain, radiating into the left lower extremity. There is numbness and tingling with the pain. He has an abnormal sensation in the right hand. He is pending physical therapy.

He is taking hydrocodone, acetaminophen, Tramadol, Zanaflex, Flexeril and Lyrica. He underwent MRI of the lumbar spine on 10/11/11.

He is 70 inches tall, and weighs 249 pounds. He has normal sensory in the lower extremities. Straight leg raise is positive bilaterally. Lumbar range of motion is reduced. Right hand grip is weaker than the left. Cervical range of motion is slightly limited with pain. He was diagnosed with lumbosacral neuritis lumbago and degeneration of the lumbar intervertebral disk and continued on his medications. He has L3-4 mild disc desiccation with

a mild broad based disc protrusion and facet disease resulting in mild acquired spinal stenosis at L4-5. There is a mild broad based disc protrusion with annular tearing of the disc within the left neural foraminal region, mild facet disease. There is mild acquired spinal stenosis with mild bilateral neural foraminal narrowing, left greater than right at L5-S1.

There is disc desiccation with moderate sized left central foraminal disc protrusion with mass effect on the ventral lateral thecal sac. Left L4-5 and L5-S1 transforaminal epidural steroid injection was planned. He was seen on 01/03/12 for transforaminal epidural steroid injection. On 02/01/12 he has left buttock pain radiating into the left leg. He has right lower extremity pain. He is pending a second ESI and has midline tenderness and bilateral paravertebral spasm.

He has no pain to palpation of either butt cheek. Motor examination is normal. He is able to stand on his heels and toes. Straight leg raise is positive at 60 degrees bilaterally. EMG/NCV study of the bilateral lower extremities has been recommended and denied.

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

This man has subjective evidence of lumbar radiculopathy with evidence of pathology on imaging without overt findings on physical examination. Nerve conduction velocity studies are not clinically indicated or supported to establish the diagnosis of lumbar radiculopathy. However, EMG of the bilateral lower extremities does conform to the ODG. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be partially overturned: The reviewer finds EMG bilateral LE is medically necessary. The reviewer finds NCV bilateral LE is not medically necessary.

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)