

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 02/10/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 Electromyography/Nerve Conduction Velocity (EMG/NCV) Testing of the Bilateral Lower Extremities between 12/16/2011 and 02/14/2012.

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 orthopedic surgery 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 1 Electromyography/Nerve Conduction Velocity (EMG/NCV) Testing of the Bilateral Lower Extremities between 12/16/2011 and 02/14/2012 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 01/30/2012
- Letter of determination from – 12/09/11,12/23/11
- Report of MRI of the lumbar spine – 08/24/10

- Report of MRI of the right hip – 11/12/10
- Report of MRI of the left knee – 07/13/10
- Initial Evaluation Report by – 12/03/10
- History and Physical by – 07/12/11
- Designated Doctor Evaluation by – 11/23/10
- Orders for EMG and NCS by – 12/06/11
- Report of Medical Evaluation – 07/12/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was loading boxes and slipped. He fell doing a split and injuring his left knee, left ankle, right hip, and lower back. He has been treated with conservative care including physical therapy and chiropractic care. There is a request for Electromyography/Nerve Conduction Velocity (EMG/NCV) Testing of the Bilateral Lower Extremities.

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

The ODG 2012, Low Back Chapter, EDS and EMG passages have been cited in reviewing this medical record documentation. It would appear that electrodiagnostic studies have a role in confirmation of radiculopathy in patients who suffer from persistent low back pain and lower extremity pain. Therefore, it is determined that the Electromyography/Nerve Conduction Velocity (EMG/NCV) testing of the bilateral lower extremities is medically necessary to treat this patient's condition.

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)