



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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Notice of Independent Review Decision

**DATE OF REVIEW:** 1/18/2012

**IRO CASE #:**

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

BILATERAL NCV/ EMG LOWER EXTREMITIES.

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

M.D. Board Certified in Neurology and Emergency 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**

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	12/29/2011
Insurance Company Utilization Review Determinations Letter to	10/17/2011-11/15/2011 12/30/2011
Diagnostic Open MRI Lumbar Spine Report	8/01/2011
Medical Group X-Rays report Office Visit Notes Assessment Plan Evaluation Summary/ Encounters and Procedures Dr. Action Sheet	7/13/2011 7/27/2011-11/28/2011 11/25/2011 10/28/2011 10/28/2011
Worker's Compensation	7/13/2011



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Progress Note	
The Orthopedic Group, LLP Office Visit Notes	8/25/2011-10/18/2011
Orthopedic Surgery Center D.O. Operative Report	9/16/2011

**PATIENT CLINICAL HISTORY [SUMMARY]**

The patient is male who sustained a work related back injury on xx/xx/xx. His clinical examination showed evidence of lower back muscle sprain and right L5-S1 radiculopathy. MRI scan of lumbosacral spine showed evidence of right L5-S1 neural canal stenosis. A request for EMG/NCS has been made to further elucidate the question of lumbar radiculopathy.

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

After reviewing the medical records provided, including historic and clinical data, imaging studies and operative notes.

The patient has unequivocal evidence of right L5-S1 radiculopathy based on clinical examination and MRI findings. No further studies, including EMG/NCS, are needed to confirm this diagnosis.

It is therefore determined that EMG/NCS is not medically necessary and denied for this patient.

**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



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- 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: