



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

DATE OF REVIEW: 7/23/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat EMG/NCV Lower Series.

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

D.O. Board Certified in Anesthesiology and Pain Management.

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
Department of Insurance Notice of Case Assignment	7/03/2013
Adverse Determination Letters	7/03/2013 5/02/2013-6/27/2013
Letter of Clarification	2/21/2013
Reconsideration Request Exam Report	6/13/2013 4/11/2013
MRI Report	5/23/2013
Mental Health Evaluation	4/29/2013
Pain Distress Assessment Procedure Report	5/02/2013



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MRI Report	5/15/2010
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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work related injury on xx/xx/xx. Patient was diagnosed with lumbar disc displacement, lumbar radiculitis, mononeuritis of the lower limb. Lumbar MRI on 1/28/2011 showed L3-4 a broad based subligamentous disc herniation which indents the anterior aspect of the thecal sac and leads to minor narrowing of the bilateral neural foramina, anterolisthesis of L4 on L5 secondary to the underlying facet arthropathy. At L5-S1 there is a broad subligamentous disc herniation more on the right than the left. An EMG/ NCV of the lower extremities dated 4/18/2012 shows findings consistent with demyelinating sensory neuropathy. X-Ray on 4/14/2012 showed degenerative disc at L4-5, grade 1 spondylolisthesis of L5 upon S1. NCV of the lower extremities on 6/21/2012 had normal findings.

X-Ray 4/11/2013 showed gentle dextroscoliosis at the mid-lumbar spine, osteopenia, thinning of the discs at the thoracolumbar junction and L4-S1 with degenerative grade-1 spondylolisthesis of L4 upon L5, stable anterior subluxation of L4 upon L5 during flexion and extension during exercises.

Patient underwent multiple treatments, back bracing, 6 sessions of psychotherapy and 14 sessions of physical therapy. On 4/25/2013, patient presented with complaint of back pain, bilateral leg pain and numbness of the toes. Physical exam showed decrease range of motion of the lumbar spine, antalgic gate positive kemps, Ely's and Nachlas tests.

5/28/2013 medical report states that the patient has back pain on the right side radiating to the right leg and foot. Exam revealed point tenderness paraspinous muscle pain associated with spasm. Decreased range of motion.

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

Per ODG, references the requested: "Repeat EMG/ NCV lower series" is not medically necessary. Patient had a previous EMG that showed demyelinating sensory neuropathy. There is no need for a repeat EMG/NCV. The findings of radiculopathy were subjective, there are no signs of peripheral neuropathies in the lower extremities to justify an NCV, and there is no comprehensive neurologic examination in the recent medical report to support the request of repeat of EMG/NCV.



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**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 KNOWLEDGE BASE
- 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