SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
7502 GREENVILLE AVENUE
SUITE 600
DALLAS, TEXAS 75231
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: February 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/Nerve conduction velocity study (to include CPT codes 95861, 95900, 95935, 95904).

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

Board Certified, Neurology; Diplomate, American Board of Pain 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

Medical records from, M.D. include:

- Department of Insurance, 09/24/07, 10/11/07, 02/15/08, 10/11/07

- M.D., 10/23/07, 02/15/08
- Medical Center, 11/20/07
- M.D., 01/17/08
- 12/05/07
- Chiropractic Clinic, 09/18/07

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2007
- P.C., 02/21/08
- M.D., 10/23/07
- Medical Center, 11/20/07
- Clinic, 11/30/07
- 12/05/07, 12/12/07, 12/14/07, 12/20/07, 12/21/07, 02/19/08
- Letter 12/5/07
- Chiropractic, 08/18/06, 08/21/06, 08/22/06, 08/23/06, 08/25/06, 08/28/06, 08/30/06, 09/01/06, 09/06/06, 09/08/06, 09/11/06, 09/13/06, 09/15/06, 09/18/06, 09/22/06, 09/25/06, 10/02/06, 10/06/06, 10/09/06, 10/13/06, 10/10/06, 10/17/06, 10/20/06, 10/23/06, 10/25/06, 10/27/06, 10/30/06, 11/01/06, 11/03/06, 11/06/06, 11/20/06, 11/27/06, 12/01/06, 12/05/06, 12/08/06, 12/13/06, 12/20/06, 12/29/06, 02/12/07, 02/26/07, 03/12/07, 04/09/07, 04/23/07, 05/07/07, 05/30/07, 06/11/07, 06/25/07, 07/13/07, 07/27/07
- Clinic, 08/25/06, 09/11/06, 10/17/06, 10/25/06, 11/01/06, 11/13/06, 11/27/06, 12/12/06, 12/13/06, 01/19/07, 03/12/07, 04/10/07, 09/18/07
- M.D., 08/21/06, 08/29/06, 09/13/06
- Clinic, 08/21/06, 08/29/06, 09/13/06, 10/04/06
- Rehabilitation Medicine, 08/31/06, 09/26/06, 09/29/06, 10/16/06
- Medical Center, 10/21/06
- Healthcare, 12/15/06, 05/23/07, 07/10/07, 08/17/07, 09/13/07
- 12/15/06, 02/08/07, 03/09/07, 05/23/07, 07/10/07, 08/17/07, 09/13/07
- Orthopaedics, 01/12/07, 02/02/07, 03/09/07, 04/17/07, 04/20/07, 06/20/07
- Hospital, 01/26/07
- Surgical Hospital, 06/29/07, 08/03/07
- M.D., 08/16/07
- Orthopaedics, 12/21/07

Medical records from the Patient include:

- Letters from unsigned, 01/28/08, 02/25/08
- M.D., 08/21/06, 08/29/06, 09/13/06
- Chiropractic, 10/17/06, 10/18/06, 10/20/06, 10/23/06, 10/25/06
- Medical Center, 10/21/06
- 12/15/06, 02/08/07, 05/23/07

- Neurology Clinic, 04/17/07
- 12/29/07
- M.D., 10/23/07
- Medical Center, 11/20/07
- Neurological, 12/06/07, 02/11/08

Medical records from M.D. include:

- Department of Insurance, 02/15/08
- Rehabilitation Medicine, 08/31/06, 09/26/06, 10/16/06

PATIENT CLINICAL HISTORY:

The patient fell on xx/xx/xx, and developed right mid thoracic pain, lumbosacral pain, and right knee pain. The patient was seen by the multiple physicians who did not record any leg pain or radicular features and found no abnormalities on neurological examination consistent with radiculopathy.

The patient was seen by D.C., on August 18, 2006. Beevor's was negative, Minors sign was negative, heel and toe walk was negative, deep tendon reflexes were normal. The patient had 5/5 muscle strength. The patient was released to return to work with restrictions.

The patient underwent physical therapy.

On August 21, 2006, M.D. mentions no leg pain or findings on examination. He prescribed Robaxin and Mobic. She was to return to work with restrictions.

Physical therapy continued.

On September 26, 2006, the patient was seen by M.D., who noted, "I find no objective evidence of serious spinal pathology, cervical or lumbar radiculopathy. Her symptoms are consistent with a strain injury." He recommended trigger point injections.

On October 16, 2006, Dr. noted the patient stated that the trigger point injections did not give her any relief. He indicated that the patient had reached maximum medical improvement, and should undergo an impairment rating and functional capacity evaluation.

An MRI of the lumbar spine on October 21, 2006 revealed a small disc herniation at L5-S1; however, there was no evidence of nerve compression.

Physical therapy continued.

An extensive review by MEd, on December 15, 2006, did not mention by history of any radicular pain.

M.D., on December 15, 2006, indicates that the patient denies any numbness, tingling, or weakness in the arm or leg.

The first objective documentation of any type of radicular pain was by M.D., on January 12, 2007, when he described right posterior thigh pain. The first time that lumbar radiculopathy was noted by Dr. was on March 9, 2007.

An EMG of the right leg and paraspinous was performed on April 17, 2007, by M.D., which also included F-waves of the right posterior tibial and peroneal, as well as extensive motor and sensory nerve conduction studies. These were completely normal.

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

In summary, an MRI of the lumbar spine did not reveal any evidence of nerve root compression. An EMG/nerve conduction study of the right paraspinous and right leg performed over eight months after the injury again did not reveal any evidence of radiculopathy. All the neurological examinations were completely normal. There was no motor reflex or sensory loss. There has been no documentation of any progressive neurological deficits. There has been nothing by history or notes or radiographic procedures to suggest any other diagnosis than a lumbar strain. I do not see any reason to perform an EMG/nerve conduction study of the lower extremities based on the above rationale and per the ODG.

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)**