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DATE OF REVIEW: February 9, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral lower extremities EMG/Nerve conduction velocity studies to include CPT codes 95903, 95861, 95904.

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

Diplomate, American Board of Internal Medicine; American College of Occupational and Environmental Medicine; American Academy of Neuromuscular and Electrodiagnostic 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 the Treating Doctor include:

- Imaging, 02/01/08
- M.D., 02/11/08, 03/26/08, 05/14/08, 08/27/08, 10/08/08, 11/12/08, 12/17/08
- Pain Management, 02/25/08, 03/17/08, 09/11/08

- Hospital, 10/03/08, 10/23/08, 12/15/08

Medical records from the URA include:

- Official Disability Guidelines, 2008
- Imaging, 02/01/08
- M.D., 02/11/08, 08/27/08, 11/12/08
- Management, 11/04/08
- M.D., F.A.A.N., 11/20/08
- Pain Management, 11/25/08
- 12/04/08, 01/08/09
- Hospital, 12/15/08
- Imaging, 12/19/08, 12/31/08, 01/20/09

Medical records from the Requestor/Provider include:

- M.D., 08/27/08, 11/12/08
- Pain Management, 11/25/08
- Imaging, 11/26/08, 12/19/08, 01/20/09
- 12/04/08, 01/08/09
- Hospital, 12/15/08
- Imaging, 02/01/08

PATIENT CLINICAL HISTORY:

This is a xx-year-old xxxx employed with the xxxx who reports a lumbar injury on xx/xx/xx . She reported to have fallen at work as her pants leg got caught in a filing drawer and she landed on her left side. The patient was found to have a grade I spondylolisthesis at L4-5 with a posterior disc protrusion at the L5-S1 level without evidence of neuroforaminal compromise.

The patient subsequently received epidural steroid injections and facet injections without improvement.

The patient underwent a lumbar myelogram and post myelogram CT scan in which the myelogram demonstrated no significant disc protrusion at the L5-S1 level. There was no evidence on the myelogram of nerve root sleeve underfilling. The post myelogram CT scan revealed mild degenerative spondylosis with mild disc space narrowing, minimal marginal osteophytes and minimal disc bulges seen diffusely across the posterior margin of each of these levels without a focal protrusion. It was noted that the central canal, lateral recesses, and neural foramina are patent.

Clinically, the patient has been continuing to complain of low back pain that radiates to her hips. M.D., her surgeon, who has consistently been evaluating the patient has found no evidence of any neurologic deficits. After she failed lumbar epidural steroid injections and facet injections, he reported that she has significant constant pain and has suggested surgery, although in his medical notes he does not indicate what surgical procedure he is suggesting. It has now been suggested that the patient should have bilateral lower extremity EMG/nerve conduction studies.

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

In my opinion, a lower extremity EMG/nerve conduction study is not indicated, and the denial should be upheld. Since her injury of xx/xx/xx, the patient has not developed any neurologic deficits. Her clinical syndrome is inconsistent with radiculopathy. Her lumbar myelogram does not reveal any evidence of a significant protrusion impinging on the thecal sac or causing nerve root filling defects. Her post myelogram CT scan also clearly demonstrates a diffuse disc bulge, however, there is no specific protrusion and it specifically notes that there is a minimal disc bulge across the posterior margin at the L5-S1 level without focal protrusion. The central canal, lateral recesses, and neural foramina are patent. Therefore, there is no objective documentation to suggest that the patient has anatomic evidence to suggest an L5-S1 radiculopathy. There is no physical examination that supports that the patient has an S1 radiculopathy. There has been no evidence of a progressive neurologic deficit. The EMG/nerve conduction study of the lower extremities would not provide any additive information. It would appear that Dr. feels that the patient is symptomatic from her spondylolisthesis, since, clearly there is no clinical evidence or diagnostic anatomic evidence of an S1 radiculopathy. An EMG/nerve conduction study of the lower limbs will not add any useful clinical information to the patient's assessment. If there were clinically significant radiculopathy present we would see it clinically now a year and 3 months out from the injury.

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) AANEM Practice Guidelines**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**