

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: March 24, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

EMG/NCV of the lower extremities x 2.

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

American Board of Orthopaedic Surgeons

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 Carrier/URA include:

- Official Disability Guidelines, 2008
- Pain Relief Center, 06/22/09, 07/06/09, 07/28/09, 08/27/09, 09/24/09, 10/06/09, 12/21/09, 01/13/10, 01/26/10, 02/10/10, 09/29/09, 02/12/10
- Behavioral Pain Management, 08/26/09, 09/11/09, 09/29/09
- MRI & Diagnostic, 10/12/09
- M.D., 12/07/09, 01/05/10, 01/26/10, 02/05/10, 03/03/10
- Outpatient Non-Authorization Recommendation, unsigned, 10/05/09

Medical records from the Treating Physician include:

- Pain Relief Center, 06/29/09, 07/28/09, 08/27/09, 09/24/09, 10/27/09, 11/24/09, 01/13/10, 02/10/10, 03/10/10, 03/15/10
- MRI & Diagnostics, 10/12/09
- M.D., 01/05/10, 01/26/10

PATIENT CLINICAL HISTORY:

I have reviewed the records of Ms., including notes from M.D., and D.C.

In reviewing all of these records, I can find no evidence that this patient has significant nerve root compression. Her reflexes have remained normal. Her motor strength has been near normal or minimally diminished. By Dr. examination, the patient's sensory examination has likewise been within normal limits.

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

By ODG Standard Guidelines, as well as my own clinical experience, I can find no evidence that this patient requires EMG studies of her cervical and lumbar spine. In my opinion, it would not be of any particular value in the further treatment of 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)