

- **Problem Focused History Examination Report dated 10/14/10, 9/13/10, 8/12/10, 7/20/10.**
- **Review of Medical Records Report dated 10/6/10, 10/1/10, 9/15/10.**
- **Progress Note dated 10/4/10, 9/29/10, 8/23/10.**
- **Communication Report dated 9/30/10, 9/15/10.**
- **Initial Interview Report dated 8/31/10.**
- **Functional Capacity Evaluation Report dated 8/17/10.**
- **Letter of Referral dated 8/10/10.**
- **Request for Authorization dated 8/10/10.**
- **Patient Information Form dated 7/20/10.**
- **Commissioner Order Form dated 7/14/10.**
- **Designated Doctor Notification Form dated 12/17/08.**
- **Consultation Report dated 8/29/08.**
- **Work Status Report dated 8/21/08, 4/20/08.**
- **History/Physical Report dated 8/7/10, 4/18/08.**
- **Follow-Up Orthopedic Evaluation Report dated 7/22/08.**
- **Addendum Report dated 6/23/08.**
- **ODG Low Back Problem Guidelines dated (unspecified date).**

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Cleaning as required by her usual occupational duties.

Diagnosis: Chronic mechanical low back pain with mild-to-moderate lumbar articular facet strain at L5-S1 and mild left-sided irritation of left S1 nerve root.

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

This female sustained a xx/xx/xx industrial lower back injury. The mechanism of injury occurred while cleaning as required by her usual occupational duties. The claimant complained of associated right lower extremity pain and weakness. The claimant has received extensive treatment including physical therapy (PT), prescribed medication management, and chiropractic treatment. The claimant has been under the care of Dr.. A non-contrast lumbar MRI scan dated 6/23/08 demonstrated peripheral annular fiber tears at L3-4, L4-5, and L5-S1 levels. Small broad-based annular disk bulges were noted at L3-4 and L4-5 levels. The L5-S1 level demonstrated a small left paracentral broad-based disk protrusion, which appeared to contact and minimally displaced the left S1 nerve root in the lateral recess. Mild-to-moderate articular facet degenerative changes were noted. The claimant underwent neurosurgical evaluation by, M.D., on 8/29/08. Dr. diagnosed chronic mechanical low back pain with mild-to-moderate lumbar articular facet strain at L5-S1 and mild left-sided irritation of left S1 nerve root. He did not find the claimant to be a surgical candidate and recommended continuing

conservative management and modified work duties. The claimant continued follow-up care with Dr. as she changed her treating doctor from Dr. to Dr. as of 7/14/10. Dr. recommended a physical performance test, pain medication referral, diagnostic X-rays, lumbar MRI scan, EMG/NCV, PT, neuromuscular electrical stimulation unit, lumbar sacral orthosis support, and foot levelers. The claimant was subsequently seen by M.D., for chronic pain medication management. Dr. prescribed the following medications: Soma, tramadol, and Vicodin patches. On 8/31/10, the claimant underwent a mental health interview and the recommendation was for her to undergo individual psychotherapy. The claimant continued follow-up care with Dr. on a regular basis. The claimant's physical examination findings by the neurosurgeon Dr. and by Dr. demonstrated no evidence of neurologic impairment with regard to motor/sensory examination and deep tendon reflexes. This decision is in accordance with the ODG. With regards to EMG, the ODG states: "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after one month's conservative therapy, but EMG are not necessary if radiculopathy is clinically obvious." With regard to NCV, the ODG states, "Not recommended. There is minimally justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy." Therefore, the requested bilateral lower extremity EMG/NCV electrodiagnostic study would not be considered medically necessary because the claimant demonstrated no documented lower extremity focal neurologic impairment to medically justify this request. Therefore, the previous adverse determination is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- AHCPH – 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Low Back Problems

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).