INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

CORRECTED REPORT
Omitted qualifications of the reviewer on 3rd page
(First page of Reviewer's Report)

REVIEWER'S REPORT

DATE OF REVIEW: 03/02/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
H reflex study, motor study, sensory study, EMG bilateral lower extremities (95934, 95903, 95904, 95861)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
Texas-licensed doctor of chiropractic, Diplomate, Congress of Chiropractic Conultants.

REVIEW OUTCOME:
Upon independent review, I find that the previous adverse determination or determinations should be:

__X___Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
	95934		*Prosp.*				*09/17/09*		*Upheld*
	95903		*Prosp.*				*09/17/09*		*Upheld*
	95904		*Prosp.*				*09/17/09*		*Upheld*
	95861		*Prosp.*				*09/17/09*		*Upheld*

INFORMATION PROVIDED FOR REVIEW:

1. Certificate of Independence of the reviewer.
2. case assignment.
3. Letters of denial 12/10/10 and 02/07/11, including criteria used in the denial.
4. Request for reconsideration 12/15/10.
5. Initial chiropractic medical report 09/14/10, and follow up 01/18/11.
6. Orthopedic evaluation 01/28/10.
7. Operative report 03/29/10.
8. Range of motion & manual muscle tests 10/05/10 and 11/18/10.
9. Pain management follow up evaluation 12/15/10.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
The patient was injured at work on xx/xx/xx. She went to a private doctor the following day with complaints of low back pain and bilateral leg pain. Sincer her injury she has had diagnostic testing and treatment to include x-rays, MRI, examinations, physical therapy, medication, three LESIs, lumbar laminectomy and post laminectomy rehabilitation.

The most recent examination findings revealed no evidence of abnormal deep tendon reflexes or abnormal or weak muscles in the lower extremities. There was no evidence of further neurological deterioration.

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

NCSs are not recommended by the ODG guideline if radiculopathy is already clinically obvious. EMGs may useful to obtain unequivocal evidence of radiculopathy, after one month of conservative therapy; however, EMGs are not necessary if radiculopathy is already clinically obvious.

DESCRIPTION AND SOURCE OF THE REVIEW CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE 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.
__X __Medical judgment, 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.
_____Pressley Reed, The Medical Disability Advisor.
_____Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
_____Texas TACADA Guidelines.
_____TMF Screening Criteria Manual.
_____Peer reviewed national accepted medical literature (provide a description).