

## Notice of Independent Review Decision

**DATE OF REVIEW:** 8/17/2007  
**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1. 95860 Needle electromyography; one extremity with or without related paraspinal areas
2. 95900 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
3. 95904 Nerve conduction, amplitude and latency/velocity study, each nerve; sensory
4. 72265 Myelography, lumbosacral, radiological supervision and interpretation
5. 62284 Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)

### **QUALIFICATIONS OF THE REVIEWER:**

This reviewer received his medical doctorate from the University of Tennessee, at Memphis. He did his internship and residency in the field of Orthopaedics at Emory University. This physician did a fellowship at Northwestern in the Department of Orthopaedics, Sports Medicine. He has been board certified in Orthopaedics since 2001. This reviewer has written numerous research articles and publications. He is affiliated with the American Academy of Orthopaedic Surgeons, American Orthopaedic Society for Sports Medicine, Arthroscopy Association of North America and the American Medical Association.

### **REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overtured (Disagree)

Partially Overtured (Agree in part/Disagree in part)

1. 95860 Needle electromyography; one extremity with or without related paraspinal areas Overtured
2. 95900 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study Overtured
3. 95904 Nerve conduction, amplitude and latency/velocity study, each nerve; sensory Overtured
4. 72265 Myelography, lumbosacral, radiological supervision and interpretation Upheld
5. 62284 Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Review organization note dated 07/27/2007
2. Request form dated 07/13/2007
3. Clinical note dated 06/08/2007
4. Clinical note dated 07/02/2007
5. Case assignment note dated 07/30/2007
6. Clinical note RN, dated 8/3/2007
7. Notice to utilization review, dated 7/30/2007
8. Clinical note MD, dated 6/8/2007
9. PA referral template RN, dated 2/8/2007
10. Clinical note dated 8/16/2007
11. Review request dated 6/5/2007
12. Request form dated 8/16/2007
13. Medical treatment dated 6/1/2007
14. Clinical note MD, dated 12/18/2000
15. Operative report MD, dated 6/28/2001
16. Follow up note DO, dated 10/10/2006

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17. Follow up note DO, dated 4/6/2007
18. Radiology report MD, dated 5/7/2007
19. Follow up note MD, dated 5/14/2007
20. Operative report MD, dated 5/23/2007
21. Follow up note MD, dated 6/1/2007
22. Clinical note dated 6/8/2007
23. Clinical note MD, dated 7/2/2007
24. Clinical note dated 6/28/2007
25. Request form dated 8/16/2007
26. Medical treatment dated 6/1/2007
27. Follow up note MD, dated 6/1/2007
28. Follow up note MD, dated 5/14/2007
29. Follow up note DO, dated 4/6/2007
30. Follow up note DO, dated 10/10/2006
31. Radiology report MD, dated 5/7/2007
32. Operative report MD, dated 5/23/2007
33. Operative report MD, dated 6/25/2001
34. Lumbar discogram MD, dated 12/18/2000
35. Clinical note dated 7/2/2007
36. Clinical note dated 8/3/2007

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This is an injured worker who has undergone decompression laminectomy with development of post-laminectomy syndrome followed by lumbar fusion with subsequent development of failed back surgery syndrome and chronic pain syndrome. On 7/2/2007 the injured worker underwent an EMG/NCS, myelogram and CT. These procedures are under review at this time.

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

The injured worker has a history of chronic low back pain status post lumbar discectomy and anterior interbody fusion at the L4-5 level. The patient's pain has recently escalated with some radicular component. The patient has been treated with activity modification, oral steroids, nerve stabilizing medication, epidural steroid injection, and physical therapy. A recent MRI demonstrated a solid L4-5 fusion and a small disc protrusion at L5-S1 level. The provider is requesting a CT myelogram and an EMG/NCV.

CT myelograms are indicated to evaluate fractures or bony destructive lesions such as infection. They are also indicated for patients, such as this, who cannot undergo an MRI, such as a patient with a pacemaker. The patient has none of these clinical indications and has already been evaluated with an MRI. Thus, there is no medical necessity for a CT myelogram, the previous denial is upheld.

EMG/NCV studies are used to delineate radiculopathy, peripheral nerve entrapment, or peripheral nerve loss. The study helps guide treatment and occasionally predicts surgical outcomes. The patient has been through numerous nonoperative measures with continued pain, and the EMG/NCV study will help determine if the patient will require operative intervention.

The ODG supports an EMG/NCV for the evaluation of radicular complaints without an obvious source. The medical necessity for an EMG/NCV is established based on the patient's complaints of radicular pain which has failed to improve after an appropriate non-operative program. The EMG/NCV will help guide further treatment and the need for any operative intervention. The previous EMG/NCV denial is overturned.

**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

**X** ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Name: Patient\_Name

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)

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