

# Independent Resolutions Inc.

An Independent Review Organization

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**DATE OF REVIEW:** JULY 30, 2007

**IRO CASE #:**

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

Left lower extremity EMG/NCV

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

Board Certified Orthopedic Surgeon

**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**

Operative report, 05/20/99, 01/04/01

Lumbar spine MRI with and without contrast, 09/06/00 and 09/11/02

Post myelogram lumbar CT scan 11/04/99

EMG/NCS, 11/07/02

Office note, Dr., 11/03/06, 12/04/06, 01/03/07, 02/02/07, 03/02/07, 03/30/07, 04/30/07 and 05/30/07

Office note, Dr., 04/16/07, 05/14/07

Notification of determination, 06/04/07

Note regarding reconsideration, No Date

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male. He is status post bilateral hemilaminectomy, L3-4, decompression of the L4 nerve roots with foraminotomies L3-4, exploration of disc bilaterally, bilateral hemilaminectomy, L4-5, decompression of the L5 nerve roots bilaterally with foraminotomies, L4-5 and excision of right herniated disc at L4-5

performed. He also underwent redo bilateral hemilaminectomies at L3-4 and L4-5 with total L4 laminectomy, bilateral hemilaminectomy L2-3 (3 levels decompressed, 2 re-do levels, at L4-5 & L3-4); decompression L3, L4, and L5 nerve roots with foraminotomies L2-3, L3-4, L4-5 & L5-S1; excision of herniated disc L3-4 from the left & excision of recurrent HNP from the right at L4-5, lateral mass fusion L3-L5 and internal fixation using screws and rods L3-5, on 01/04/01. It was noted that he also had another surgery, however the type and date were not provided.

A lumbar MRI performed on 09/11/02 revealed previous decompressive laminectomies at L3-4 and L4-5 with posterior lumbar fusion between L3 and L5 with bilateral pedicle screws and rod fixation; dehydration with 2-3 millimeters of generalized disc protrusion spanning the L2-3 disc and extending into each neural foramen. The thecal sac was mildly flattened diffusely and bilateral neural foraminal compromise as a result of the disc material and mild facet arthropathy. These changes are slightly greater on the right than the left. There was bilateral facet arthropathy at L5-S1 with neural foramen lower normal in size. EMG/NCS studies of the lower extremities performed on 10/07/02 demonstrated evidence of multi-level lumbosacral radiculopathies bilaterally localized to L4-S1 nerve root levels.

The claimant had continued intractable back pain and bilateral leg pain which was affecting his activities of daily living and quality of life. Dr. visits between 11/03/06 and 03/30/07 revealed the claimant's requirement for a cane as well as examination findings such as diminished reflexes of the knees and ankles and a positive seated root test. Plain films including flexion/extension films performed on 03/30/07 showed a slight pelvic tilt with grossly intact hip and sacroiliac joints, intact hardware from L3-5, a wide decompression extending from L3-5, a considerable amount of spurring on the vertebral bodies and decreased disk space at L2-3 and L4-5 with an apparent fusion. There was no movement with flexion/extension and no significant loosening of the hardware.

The claimant was referred to and seen by Dr. on 04/16/07 noting worsening pain, difficulty getting from seated to standing, and an antalgic gait. He was unable to hip flex due to pain and quadriceps extension, plantar and dorsiflexors were 4+/5. Dr. reviewed the plain films stating there was pedicle screw construct from L3-5, severe and dramatic syndesmophytes at L2-3, L1-2 and T12-L1, modest kyphotic deformity at L2-3, large anterior syndesmophytes which have not quite kissed with moving at that segment. There was no hardware loosening, but no bone in the intertransverse area either and an air vacuum phenomenon at L4-5. EMG/NCV studies of the lower extremities, myelogram and post CT were ordered.

On 04/30/07 he noted a painful knot in his back at the midline thoracolumbar region. X-rays showed significant spurring where the knot was. There was no bony prominence and there was no soft tissue seen on lateral view. The EMG/NCV studies of the right lower extremity were denied. Dr. re-evaluated the claimant on 05/14/07 noting a very sensitive area on the spinous process with basically reversal of lumbar lordosis. His balance was questioned. The seated straight leg raise was positive for back pain only. A spinal cord stimulator was to be considered, after ruling out a transitional problem accompanying the stabilization process.

The EMG/NCV studies of the left lower extremity were denied on 06/04/07 and 06/22/07 and are currently under dispute.

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

This gentleman has a history of multiple lumbar surgeries including decompressions and discectomies at multiple levels with redo procedures subsequently thereafter and a more recent fusion procedure. Records document extensive treatment following the ongoing surgeries. When seen by Dr. in April of 2007, EMGs were recommended due to increasing leg pain. It appears, based on the records that those studies were denied based on the fact that the previous set of EMGs from 2002 had identified the diagnosis of multi level lumbar radiculopathies, but no evidence of distal neuropathic process. The request was made for repeat studies. Based on the information available, it appears that that request was generated in light of a description of worsening clinical complaints, particularly in the lower extremity. These include difficulties with hip flexion secondary to pain and deficient quad strength on exam.

Previous reviewer suggested that the EMGs were unlikely to be of significant benefit in light of the fact that there had been no clinical change. The Reviewer would submit that the records would suggest otherwise. In particular, the increasing pain complaints and the weakness that may be more proximal to the previously described overt abnormalities on EMGs would suggest that the additional set of EMGs as recommended would appear to be reasonable and medically necessary. While the EMGs are quite likely to show pre-existing pathology, an obvious change would be consistent with the patient's clinical picture and the absence of change would be reassuring to both the patient and treating physician that the subjective complaints of pain were not a reflection of significant neural compression. As such, the Reviewer would consider the request as being reasonable and medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Low Back-EMG & NCS studies)

**ODG Guidelines–EMG**-Recommended (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.

**NCS Studies** - Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy.

**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)