

# **RYCO MedReview**

## **Notice of Independent Review Decision**

### **IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 05/07/07

**IRO CASE #:**

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

Repeat bilateral lower extremity EMG/NCV study

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

Board Certified in Physical Medicine & Rehabilitation

#### **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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

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

An MRI of the lumbar spine interpreted by M.D. dated 12/14/04  
An EMG/NCV study interpreted by, M.D. dated 12/28/04  
Evaluations with M.D. dated 03/28/05, 05/18/05, 08/10/05, 08/31/05, 09/07/05,  
11/02/05, 01/11/06, 01/23/06, 04/12/06, and 01/31/07  
A note from at Dr. office dated 10/10/05  
An evaluation with D.C. dated 02/01/07  
A referral from Dr. dated 03/01/07  
A preauthorization request from M.D. dated 03/08/07  
A letter of non-certification from L.L.C. dated 03/13/07  
A letter of appeal from Dr. dated 03/19/07  
A letter of denial from the insurance carrier dated 03/27/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

An MRI of the lumbar spine interpreted by Dr. on 12/14/04 revealed degenerative changes with a minimal disc protrusion at L5-S1. An EMG/NCV study interpreted by Dr. on 12/28/04 revealed left L5 motor and bilateral S1 sensory radiculopathy and ongoing right S1 and left lower lumbar paraspinal radiculopathy. On 05/18/05 and 08/10/05, Dr. requested lumbar surgery. On 09/07/05, Dr. requested a walking program. On 11/02/05, Dr. recommended a rehabilitation program. On 01/31/07, Dr. requested removal of lumbar hardware. On 02/01/07, Dr. requested active rehabilitation and repeat lumbar MRI and EMG/NCV study. On 03/08/07, Dr. wrote a letter of preauthorization request for a repeat EMG/NCV study. On 03/13/07, wrote a letter of denial for the repeat EMG/NCV study. On 03/19/07, Dr. wrote an appeal for the EMG study. The insurance carrier wrote a letter of denial for the EMG/NCV study on 03/27/07.

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

A repeat electrodiagnostic examination of the bilateral lower extremities is not recommended as medically stable. It appears from Dr.'s records on 01/31/07 that the patient's x-rays revealed loosening of the S1 screw on the right side. According to the surgeon, this could explain many of the symptoms the patient was having with low back pain as well as the S1 nerve root. He recommended removal of the hardware and fusion exploration with right foraminotomies at L5-S1. He was having right radicular pain identified at that time due to this screw loosening. Because the patient has clinical symptoms of right lower extremity radicular pain that have been present since the time of surgery, electrodiagnostic testing is not necessary. Also of note, the examination of Dr. is incomplete with only partial reflex testing performed. His examination also appeared to be inconsistent with patient having symptoms of possible bilateral lower extremity radicular pain with evidence of multiple trigger points and "myospasms." It appears the patient has failed previous treatment including therapy. He does not complain of a particular radicular pain, just numbness. Based upon that, a repeat

bilateral lower extremity EMG/NCV study would not be helpful and therefore not be warranted.

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

- X 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 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)**

