ZRC MEDICAL RESOLUTIONS INC

REVIEWER'S REPORT

DATE OF REVIEW: 07/31/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Electrodiagnostic testing.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.C., D.O., M.S., Board Certified in Chiropractic, Physical Medicine and Rehabilitation, Pain Management

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:
1. I reviewed an MRI report authored by Dr. dated 02/20/08. The impression was "disc herniations identified at L1/L2, L3/L4, and L4/L5, disc protrusion at L5/S1 and disc bulge at L2/L3. Other findings as noted above."
2. An x-ray report of 06/06/08 read by the same radiologist shows "facet arthropathy, spinal stenosis, spondylosis, osteopenia." This was all of the lower back.
3. I reviewed a report from Dr. dated 06/06/08. The assessment was "lumbar pain with intermittent lower extremity weakness and numbness, rule out radiculopathy, rule out spinal stenosis, rule out lumbar facet arthropathy, rule out sacroiliitis complicated by sacroiliac dysfunction." According to the body of that report, he had increased numbness and tingling in his legs with sitting more than twenty minutes. He underwent therapy for two weeks and felt somewhat better, then the pain returned. Coughing and sneezing made the pain worse. Bending forward to brush his teeth made the pain worse. On examination that day, straight leg raising signs were negative. He had tenderness over the left sacroiliac joint. He had tenderness in the right side of the lower back, and Patrick-Fabere test was positive on the right side. He reported decreased sensation over

181 Ruby Lake Drive
Kyle, TX 78640
512.535.2922 * 512.853.9371 (fax)

the right lateral thigh, right medial calf and thigh, and lateral calf. No motor weakness was noted.
4. I reviewed blood study results from 06/11/08.
5. I reviewed a 06/20/08 report from Dr.
6. I reviewed a report from Dr. dated 07/24/08. The note indicated he had prior surgery in xxxx on his lower back. Denial for EMG study was because there was no documented motor weakness or sensory impairment.
7. I reviewed a 06/25/08 report from Dr.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This is a male with a history of developing back pain on xx/xx/xx when he fell at work. He had a prior history of low back surgery in xxxx. He has had some physical therapy with persistent symptoms. He had an MRI scan showing disc herniations at L1/L2, L3/L4, and L5/S1 with a disc protrusion at L5/S1. Request has been made for bilateral lower extremity nerve conduction velocity studies and bilateral lower extremity EMG testing.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
This is a middle-aged male with multilevel degenerative changes in the lumbar spine with multiple disc herniations/protrusions with predominantly right leg pain. His examination did suggest a right-sided radiculopathy on 06/06/08 when he was identified to have sensory changes in the right lower extremity, although the muscle testing was normal. Straight leg raising signs were also normal at that time. Lab studies showed increased blood sugar, but he has not been diagnosed for diabetes from the records I have reviewed. There was a note of 06/20/08, but there was no physical examination. There was a 06/25/08 report, which was not based on a physical examination but a letter from Dr.

According to the ODG Guidelines, an electromyography is recommended as an option "to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but EMG studies are not necessary if radiculopathy is already clinically obvious. No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common, and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. EMGs may be required by the AMA Guides for an impairment rating of radiculopathy." In regard to nerve conduction studies, the ODG Guidelines, again on the on-line version, state, "Not recommended. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy."

In summary, there is not anything to suggest a radiculopathy in the left leg, and therefore, EMG testing of the left lower extremity is not indicated. Based on ODG Guidelines when we are looking at a rule-out diagnosis of radiculopathy, nerve conduction studies are not recommended. The only area where needle EMG testing may be indicated in this case would be in the right lower extremity and right lumbar paraspinal region based on the sensory changes of the clinical examination of Dr. In this case, however, either all of

181 Ruby Lake Drive
Kyle, TX 78640
512.535.2922 * 512.853.9371 (fax)

the NCV and EMG is supported or none of it is supported. Therefore, it is my opinion that the requested bilateral lower extremity NCV/EMG is not recommended.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

_____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).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)

181 Ruby Lake Drive
Kyle, TX 78640
512.535.2922 * 512.853.9371 (fax)