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Notice of Independent Review Decision

DATE OF REVIEW: 11/13/2008

IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV bilateral lower extremities

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

Certified by the American Board of 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	724.4	95861	Upheld
		Prospective	724.4	95903	Upheld
	xxxxx	Prospective	724.4	95904	Upheld

Official Disability Guidelines EMGs

PATIENT CLINICAL HISTORY:

This is a xx-year-old gentleman with an objectified date of injury of xx/xx/xx. The reported mechanism of injury is a fall from an elevated surface. This was treated with multiple methodologies and chiropractic care. Plain films noted multiple level degenerative changes L3 – S1. CT of the lumbar spine noted minimal disc bulges at all levels with no nerve root encroachment identified. Facet arthrosis is reported.

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

It was felt that the above findings were indicative of a lumbar radiculopathy. However, the specialty consultant did not note that as an assessment or diagnosis in this case. The treatment was to administer trigger point injections. It was noted that DTR's were intact. In June 2004 epidural steroid injections were administered.

A February 2005 myelogram noted minimal disc bulges and osteophytosis. The notes report that an EMG was scheduled. The needle EMG was not completed until July 13, 2005, xx months after the date of injury. It was noted that there were no signs of acutely or actively denervating radiculopathy, completed the EMG. Repeat imaging studies noted "advanced osteoarthritic changes in the right femoral head".

A repeat electrodiagnostic assessment was requested and not certified. In the request for reconsideration; the parameters for the non-certification were presented and again not certified. In the request for IRO determination it is notes that it was identified that there was no evidence of a verifiable radiculopathy two years after the date of injury. It was also noted that there are forgoing chronic pain issues. It is indicated that the repeat electodiagnostic assessment was to ascertain the presence of radiculopathy to support an impairment rating determination.

It was noted that a DRE III level impairment rating was assigned for the lumbar spine injury. This was based on the ongoing difficulties relative to standing. In the evaluation the results of the prior EMG are not noted, the results of the MRI and other imaging studies are not noted. There is no competent, objective, and independently confirmable medical evidence presented of a lesion that would be causative of a verifiable radiculopathy. It is noted that there is maximum medical improvement in January 2006.

As noted in the Division mandated Official Disability Guidelines under EMGs:

Recommended as an option (needle, not surface) EMGs (electromyography)

may be

useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if **radiculopathy is already clinically obvious**. (Bigos. 1999) (Ortiz-Corredor. 2003) (Haig. 2005) 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 (Dimopoulos. 2004) EMGs may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA 2001)

It is stated that the repeat EMG is needed to support a DRE III level impairment rating. There are several points to be made. First, the impairment rating is to be based on the compensable injury alone. The imaging studies noted that there was no nerve root encroachment as a sequale of the compensable event. The injured

employee has a noted osteoarthritis in the spine and lower extremity. If there is a nerve root problem, at this time, it is not a function of the compensable injury.

Second, the impairment rating is to be based on the condition at the time of maximum medical improvement. In that there were prior impairment ratings completed and it is

presumed that there was lost time prior to this date, the statutory application of maximum medical improvement is to be considered.

Third, there was an EMG completed xx months after the date of injury. Had this injury been causative of verifiable radiculopathy, then the changes would have been noted at the time of the earlier EMG. Furthermore, there were no difficulties with the lumbar paraspinals, indicating that the issue is with the arthritis and not the nerve root.

Fourth, as noted in a number of Appeals Panel decisions, in addition to the electrodiagnostic findings, there is to be a loss of relevant reflexes. It is noted that there is an absence of the Achilles reflex bilaterally. Consequently, there is no objectification of a verifiable radiculopathy based on the physical examination reported. In the alternative, both the Guides and the Appeals Panel note that if no loss of relevant reflexes there is to be an atrophy greater than 2 cm. The physical examination reported in the requesting providers' impairment rating does not note any atrophy. With the failure to document these two lesions, irrespective of the EMG findings there is no basis for a DRE III level impairment rating. That being the case, and it is indicated that the reason to obtain the EMG is solely to support the impairment rating assigned, there is no clinical basis to repeat the EMG well after the presumed statutory date of maximum medical improvement.

When noting the ODG recommendation listed above, verifiable radiculopathy has been ruled out. With the clinical data already presented establishing that there was no verifiable radiculopathy xx months after the date of injury, it is the opinion of the Reviewer that a repeat EMG for the purposes of impairment rating is not medically necessary.

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)