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**DATE OF REVIEW:** 09/08/2008

**IRO CASE #:**

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

Lower extremities EMG/NCV 06/12/08.

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

This case was reviewed by a Texas licensed MD, specializing in Neurological Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Neurological Surgery

**REVIEW OUTCOME:**

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Lower extremities EMG/NCV 06/12/08.		-	Upheld

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient is a male who is reported to have sustained a work related injury on xx/xx/xx. He reports walking up the stairs when he slipped, fell forward onto his face. He reports pain starting within the next

week in his low back and right lower extremity. On 05/04/05 the patient was evaluated by Dr. At this time the patient reports persistent pain in the low back and right side down the buttock and then into the right lower extremity, at times into the foot involving all of his toes. He describes the pain as aching. He reports lower extremity pain, tingling and a burning sensation. He has not had any physical therapy or previous surgery or injections. MRI of the lumbar spine was performed on 02/23/05 which is reported to show a right paracentral disc protrusion at L4-5 with mass effect on the right L5 nerve root. On physical examination the patient is reported to be well developed and well nourished. On examination of the back there is no CVA tenderness. Deep tendon reflexes are 2+ bilaterally. Toes are downgoing bilaterally. Motor examination is non-focal. Lower extremity motor strength is graded as 5/5. He is reported to have a positive straight leg raising on the right at approximately 45 degrees with worsening pain with foot dorsiflexion. He has some tenderness over the right paraspinal musculature. The patient is diagnosed with low back pain, lumbar HNP without myelopathy and lumbosacral radiculopathy. Dr. recommends authorization for lumbar transforaminal epidural at the L4 and L5 nerve root levels.

The patient was seen in follow up by Dr. on 07/26/05. The patient's physical examination is unchanged. He subsequently is again recommended to undergo transforaminal epidural steroid injections at L4 and L5. The record contains an MRI of the lumbar spine dated 05/12/06. This study reports a loss of height and decreased signal in all pulse sequences in the L4-5 intervertebral disc region. There is mild spondylosis present throughout and there is a slightly larger osteophytosis along the vertebral body endplates at L4-5

and along the facets at L4-5. There is moderate neural foraminal narrowing present at this level. There is slightly greater narrowing of the spinal canal at this level although there is no significant spinal cord narrowing at any of the levels. No disc bulging or focal disc protrusion is present. There is no evidence of nerve impingement. The overall impression is disc desiccation and loss of height at L4-5 disc with mild to moderate spondylosis at this level and mild spondylosis at other levels. On 06/12/08 the patient was referred to Dr. It was reported that the patient has had intermittent low back pain since the fall of xxxx when he fell down some steel stairs. He reports having low back pain which radiates into the legs worse on the left side. He gets some radiation up the back into the neck. He has previously been seen by Dr. in the past and it sounds as though he has had some injections perhaps trigger point injections that helped at least temporarily. He again has been having more back pain recently. On physical examination the patient is 6'0" and weighs 200 pounds. His cranial nerves are intact. He has good strength proximally and distally in the arms and legs. He is able to walk on his heels and toes. Deep tendon reflexes are 2+ and symmetric. Ankle jerks are present. Plantar responses are flexor bilaterally. Sensory examination is remarkable for some stocking distribution hypoesthesia to vibration and pinprick. He has a normal posture and gait. He is able to walk on his heels and toes. Dr. recommends an EMG/NCV study of the legs to rule out significant lumbosacral radiculopathy. He recommends placing the patient on low dose Cymbalta. On 06/19/08 the case was reviewed by Dr. Dr. noncertified the request. She reports that she reviewed the clinical information submitted and the ODG guidelines. She reports that f-wave test and NCV are not recommended. She reports the documentation submitted does not support the necessity of these requests. The request was appealed and subsequently reviewed by Dr. on 07/08/08. Dr. reports a lack of evident findings on exams or imaging to support the need for EMG/NCV of both legs. The patient has only pain complaints without suspected neurologic deficit. He reports the request is not supported by ODG.

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

Items in dispute: EMG/NCV of the lower extremities

I would concur with the two previous reviewers in that there is insufficient clinical evidence to establish the medical necessity of this request. The patient has a xx/xx/xx date of injury. The early medical records submitted indicate that the patient fell forward on some stairs and later developed low back and right lower extremity pain. The patient was recommended to undergo lumbar epidural steroid injections at L4 and L5; however, the record does not establish that these were ever performed. The record does include an MRI of the lumbar spine dated 05/12/06. This study shows no evidence of disc protrusion or herniation or neural compressive lesion. The record does not provide any other imaging studies to suggest presence of a neural compressive lesion. Most recent examination is dated 06/12/08 which indicates that the patient has had intermittent symptoms for years and that he has been treated conservatively and may have had some injections. The patient's examination is remarkable for some stocking distribution hypoesthesia but motor strength and deep tendon reflexes are intact. It is further noted that at this time the patient is reported to have low back pain radiating into the left leg which is not consistent with the patient's early reports. Clearly there is insufficient information contained in the clinical record to establish the medical necessity of this request.

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

Reference:

The Official Disability Guidelines, 11th edition, The Work Loss Data Institute.