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Notice of Independent Review Decision

DATE OF REVIEW: 3/13/09

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Nerve conduction velocity test (NCV)

REVIEW OUTCOME

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

Overtuned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o January 7, 2009 Radiology Report from Dr.
- o January 21, 2009 Medical report from Dr.
- o January 28, 2009 Medical report from Dr.
- o February 3, 2009 Report of Medical Necessity from Neuro Diagnostics
- o February 4, 2009 Medical report from Dr.
- o February 5, 2009 Referral form for Nerve Conduction Velocity test from Dr.
- o February 5, 2009 Letter of non-certification for NCV
- o February 13, 2009 Letter for reconsideration from Dr.
- o February 19, 2009 Letter of non-certification for reconsideration for NCV
- o March 2, 2009 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is an employee who sustained an industrial injury to the low back, date of injury not specified.

Lumbar MRI was performed on January 7, 2009 and shows signal alteration of the opposing endplates of L1 and L2; the appearance is probably related to chronic bone bruise or bone contusion. Practically there is no evidence of acute fracture, dislocation, bone bruise, or bone contusion. No evidence of solid or cystic bone lesions. Diffuse degenerative changes noted with several anterior and anterolateral osteophyte formations noted. There is lumbar spinal stenosis caused by congenitally short pedicles. This would aggravate the effects of the disc bulges or herniations. At L4-5 there is a 3 mm central disc herniation with impingement on the central aspect of the thecal sac. At L4-5 there is anterolisthesis of L4 over L5 with kinking of the thecal sac at this level. There is a 3 mm posterior and central disc protrusion with impingement on the central aspect of the thecal sac. At L5-S1 there is a 2 mm posterior disc bulge with some impingement on the thecal sac.

The patient was reevaluated on January 21, 2009. She is not working and reports a pain level of 10/10. She reports low back pain that radiates to the legs that increases with activities and makes sleep difficult. She reports shock-like sensations with muscle spasms and joint pain in the knees. Medications include Bystolic, Altace and Darvocet-N 100 twice daily. Blood pressure is 160/90. Tenderness was noted in the lumbar region on the left and muscle spasm in the right and left lower lumbar regions. Straight leg raise is noted as positive without further clarification. The knee is tender to palpation with no swelling or warmth. Knee motion is abnormal and painful. Apley's compression test is positive. Recommendation is for a back brace, knee brace, analgesics, one month of rehab and return in one week.

The medical report of January 28, 2009 indicates the patient has seen a specialist who recommended MRI. She reports low back pain that radiates to the legs and intermittent locking of the knee. Lower extremity weakness, not further clarified, is observed.

The patient was seen again on February 4, 2009. Her symptoms are unchanged. She reports limb weakness, limping and numbness of the left leg. Tenderness and muscle spasm are noted in the lumbar region. The knee is tender to palpation and a muscle spasm is noted. There is weakness in plantar flexion.

Request for nerve conduction study and EMG was not certified in review on February 5, 2009 with rationale that the patient has not failed conservative care and the rationale for the study was insufficient per the Official Disability Guidelines. The medical records failed to clarify the nature or cause of the patient's injury. Additionally, a comprehensive history and physical including, bowel, bladder or other pertinent reflexes is needed. The patient complains of back pain without clarification of the precipitating events.

The provider responds with a letter for reconsideration on February 13, 2009. Additional information is submitted in regards to a recent evaluation and consultation report from a spine surgeon. The patient has completed the maximum allowable therapy sessions under ODG and continues to report severe pain and ongoing radicular complaints into her lower extremity. The MRI showed multiple disc herniations from L1 through L5 with impingement of the thecal sac at every level. Per specialty consultation opinions, the requested studies are necessary. The patient has not improved with the treatment provided and, the information from the requested studies will help the specialist determine the pain generator and best course of care.

Request for reconsideration was not certified in review on February 19, 2009 with rationale that ODG states EMG/NCV studies are not necessary if radiculopathy is already clinically obvious which is the case for this patient. The patient has back pain, radicular pain, weakness and numbness in the setting of a markedly abnormal MRI. There is no useful clinical information to be gained from EMG/NCV, as the patient's diagnosis is obvious.

On March 2, 2009 the provider requested an IRO.

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

MRI shows diffuse degenerative changes with several anterior and anterolateral osteophyte formations, lumbar spinal stenosis caused by congenitally short pedicles which would aggravate the effects of disc bulges or herniations. At L4-5 there is a 3 mm central disc herniation with impingement on the central aspect of the thecal sac. At L4-5 there is anterolisthesis of L4 over L5 with kinking of the thecal sac. There is a 3 mm posterior and central disc protrusion with impingement on the central aspect of the thecal sac. At L5-S1 there is a 2 mm posterior disc bulge with some impingement on the thecal sac. The MRI findings do not predict the patient's clinical picture. Clinically, the patient reports shock-like sensations, subjective weakness, muscle spasms and knee problems. Straight leg raise is merely reported as positive without further clarification. On January 21, 2009, one month of rehab is recommended. Two weeks later some weakness is reported in left plantar flexion and the patient has a slight limp. Electrodiagnostic studies are recommended by consultation opinions and by the provider but are denied initially for lack of reporting details and lack of exhaustion of conservative care and secondarily as radiculopathy is obvious and the studies are not needed.

Per The Official Disability Guidelines, EMGs are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The patient's radicular findings are primarily subjective with exception of weakness noted in plantar flexion. Additionally, the patient has knee conditions which complicate her clinical picture. MRI findings do not show a specific surgical lesion and the degree and distribution of radiculopathy are not clarified. In this case, it would be reasonable for the patient to have electrodiagnostic studies to clarify radiculopathy versus distal pathology and allow for better long term treatment planning. Therefore, my determination is to overturn the previous non-certification of nerve conduction velocity test (NCV).

The IRO's decision is consistent with the following guidelines:

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

- DWG- 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

The Official Disability Guidelines - Lumbar - Nerve Conduction Studies - February 19, 2009:

Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.