

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lower Extremity EMG/NCV

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management
Board Certified in Electrodiagnostic Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was injured on xx/xx/xx when he was struck on the lower back/buttocks by a loose saw blade. The records indicate this was a blunt trauma injury with no cut. He was felt to have stenosis and underwent disc surgery with left sided laminectomy at L2-3 and L4-5 in 2008. He had ongoing back symptoms. A repeat MRI in October 2008 showed moderate to severe stenosis at L3/4 with bilateral recess stenosis, lesser central and lateral recess

stenosis at L4/5 and lesser foraminal stenosis at L5/S1. A CT scan in November 2008 showed essentially the same thing. The patient was seen by Dr. He described weakness in the left lower extremity and the right lower extremity. Knee jerks were 2+ and ankle jerks were 1+. SLR was bilaterally positive.

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

The claimant apparently was felt to have a radiculopathy from the work related injury that was not related to the preexisting degenerative changes described in the radiological reports of the spine. He remains symptomatic since surgery. The radiological findings show multiple level spinal stenosis. Dr. wrote "The patient tells me he does not want to have surgery and that he is not sure about injections because he is concerned it may be dangerous." The AMA Guides utilize the EMG to confirm the presence of a radiculopathy. The ODG recognizes the need for an EMG to determine the treatment of a radiculopathy when it is not clinically obvious. This man has multiple-level pathology that can be the cause of the radicular symptoms. The records reviewed did not show any specific dermatomal pattern for the pain. The physical findings showed multiple myotomal weakness. The EMG could be appropriate to determine which level surgery would be necessary, however the records indicate this man does not want surgery. An EMG would be appropriate if the surgeon was considering limited nerve root decompression, but not if the procedure involved the areas described on the CT scan and MRI. Since epidural injections are not deemed effective in the treatment of spinal stenosis (separate from a diagnostic block), the EMG would not help in determining what level to inject. The request does not conform to the guidelines. There is no justification for the electrodiagnostic studies provided in the records for this review. The reviewer finds that medical necessity does not exist for Lower Extremity EMG/NCV.

EMGs (electromyography)

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) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended. See Surface electromyography.)

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

ACOEM-AMERICA 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)