



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 5-8-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

95934 Repeat H reflex test bilateral lower extremities x 2; 95903 repeat EMG bilateral lower extremities x 4; 95904 repeat sensory nerve conduction studies bilateral lower extremities x 2.

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

Board Certified in Occupational Medicine, American Board of Preventive 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Medical Group
- DC., office visits from 6-7-07 through 4-15-09.
- 6-18-07 MRI of the lumbar spine.
- MD., office visits from 7-3-07 through 2-13--09.
- MD., office visits from 7-17-07 through 12-9-08.
- 8-2-07 MRI of the cervical spine.
- 8-14-07 A Behavioral Health Assessment.
- 8-22-07 EMG/NCS performed
- MD., office visits from 11-15-07 through 8-4-08.
- 12-7-07, C6-C7 transforaminal epidural steroid injection and trigger point x 4 to the cervical paraspinal.
- 2-6-08 electrodiagnostic testing of the upper extremity performed
- 2-13-08 Surgery: anterior cervical decompression discectomy C4-C5 bilaterally, corpectomy at C4-C5-C6, cage placement C4-C5 and C5-C6, anterior arthrodesis C4-C5 and C5-C6, anterior instrumentation segmental fixation C4, C5, C6 bilaterally.
- 5-7-08 Lumbar myelogram.
- 7-11-08, MD., CT myelogram review.
- 8-14-08 MD., office visit.
- 8-25-08 MD., performed a Peer Review.
- 9-10-08 right L4-L5 transforaminal epidural steroid injection and trigger point injections.

- MD., office visits from 12-8-08 through 2-20-09.
- Chronic Pain Management from 1-26-09 through 2-9-09.
- 3-2-09 pre-authorization request for EMG/NCS of the lower extremities.
- 3-5-09 DO., provided an adverse determination.
- 4-8-09 Appeal from Dr.
- 4-14-09 MD., provided an adverse determination.

PATIENT CLINICAL HISTORY [SUMMARY]:

The Employer's First report of injury notes the claimant sustained a work related injury on xx-xx-xx. On this date, the claimant slipped, but did not fall.

The claimant sought medical attention at Medical Group with complaints of low back pain. The claimant had tenderness to right paraspinal muscles in the lumbar spine with decreased range of motion. She had negative SLR, sensation was intact. The claimant was provided with medications and referred to physical therapy. The evaluator returned to claimant to work with restrictions. It was noted the claimant had a past medical history of prior lumbar surgery 7 years ago.

The claimant then sought medical attention under the direction of, DC., on 6-7-07 and began a course of chiropractic therapy.

MRI of the lumbar spine dated 6-18-07 showed intraosseous disc herniations at L1-L2 and L2-L3 levels. At L4-L5 severe degenerative disc disease noted with segmental instability. An annular bulge is present with bilateral facet joint arthrosis and severe narrowing of the right with moderate narrowing of the left neuroforamen. At L5-S1, a 3.0 mm right subarticular and foraminal disc herniation is present flattening the thecal sac with moderate facet joint arthrosis and moderate bilateral foraminal narrowing.

The claimant was evaluated, MD., on 7-3-07. The evaluator noted the claimant had prior lumbar spine surgery by Dr. in 2002 to include L4-L5 and L5-S1 microsurgical techniques. The claimant reports neck pain and radiating to her upper extremity with numbness and tingling, as well as lower back pain and right leg pain. The evaluator recommended the claimant continue with her workup in the cervical spine with MRI scan. The evaluator reported that if she continued to have the amount of symptomatology, she would probably require surgery to the lumbar and lumbar spine.

Follow up visit with Dr. on 7-17-07 notes the MRI results of the lumbar spine were reviewed. The claimant would like to have surgical intervention to the lumbar spine, which he agreed on. The evaluator recommended a cervical spine MRI.

The claimant was evaluated by MD., on 7-17-07. On exam, the claimant had tenderness to the lower thoracic spine. The paraspinal musculature is tender to palpation. Reflexes were present in all limbs. Right and left SLR arouses pain on the lower thoracic spine, which radiates to the pelvis. The evaluator felt the claimant sustained cervical, thoracic and lumbar strain with pain radiating to pelvis. The evaluator recommended the claimant continue with Dr. for therapy, continue with Dr. for orthopedic care. The claimant was provided with a prescription for Soma 350 and recommended home treatments with hot and cold packs and analgesic creams.

MRI of the cervical spine dated 8-2-07 shows posterior protrusion-subligamentous disc herniation at C4-C5, C5-C6 and C6-C7. Straightening of the cervical lordosis curve consistent with muscle spasm.

Follow-up with Dr. on 8-7-07 notes the claimant's exam is unchanged. The claimant would like to proceed with surgical intervention. The evaluator noted that since the lumbar spine was bothering her more, he would proceed with this first.

A Behavioral Health Assessment dated 8-14-07 shows there was no contraindication for the proposed surgery.

8-22-07 EMG/NCS performed by MD., showed an indication of acute irritability in the bilateral L4 and L5 motor roots with some chronic neuropathic changes in the S1 distributions bilaterally. There is mild involvement of the lower sacral S2-S4 consistent with her urinary dysfunction following this date of injury.

Medical records reflect the claimant continued to receive chiropractic therapy under the direction of Dr. the claimant was also seen by Dr. for medications.

On 11-15-07, the claimant was seen in consultation by MD. The claimant reported neck, lower back and mid back pain. The claimant was seen for further management. The claimant reported her neck pain was about 9/10 and the low back pain 10/10. The claimant also reports right lower extremity radicular complaints and radicular right upper extremity complaints. On exam, the claimant has tenderness to the cervical region and facets. The claimant has paresthesias in the C5 distribution on the right side. Spurling's is negative. The claimant has multiple trigger points paraspinal on the right side. Decreased sensation at right L5-S1 distribution. The evaluator recommended epidural steroid injection of the cervical spine at C5-C6 level.

On 12-7-07, the claimant underwent C6-C7 transforaminal epidural steroid injection and trigger point x 4 to the cervical paraspinal.

Follow-up with Dr. notes the claimant did not respond to the epidural steroid injection and would require an anterior cervical decompression surgery.

On 1-15-08, Dr. reported the claimant's neck pain and bilateral upper extremity pain worse on the right than the left and lower back pain. The evaluator reported the claimant would proceed with cervical ACDF at C4-C5 and C5-C6 due to failure of conservative treatment.

On 2-6-08, electrodiagnostic testing of the upper extremity performed by, MD., showed acute/subacute right C5 radiculopathy. There is evidence of a focal compression neuropathy of the right medial nerve at the level of the wrist.

On 2-13-08, the claimant underwent anterior cervical decompression discectomy C4-C5 bilaterally, corpectomy at C4-C5-C6, cage placement C4-C5 and C5-C6, anterior arthrodesis C4-C5 and C5-C6, anterior instrumentation segmental fixation C4, C5, C6 bilaterally.

Postoperative, the claimant reported some neck stiffness but no arm pain. The claimant continued with a limp on the right side. Dr. recommended proceeding with lumbar surgery.

A lumbar myelogram dated 5-7-08 showed spondylitic changes L4-L5 without evidence of acute soft disc protrusion or high-grade canal or foraminal stenosis. Post CT scan showed spondylitic change L4-L5 with broad based disc bulging and prominent endplate sclerosis and reactive change. Anterior calcification of the capsule of the right L4-L5 facet joint with associated mild narrowing of the right L4-L5 neural foramen.

Follow-up with Dr. dated 5-11-07 showed the claimant is quite pleased with the cervical spine surgery. She has no headaches, no complaints of radiculopathy in her upper extremities. She only has minimal neck stiffness. The evaluator noted that the claimant had failed conservative treatment for greater than a year for the lumbar spine and standard of care requires decompression and stabilization of recurrent HNP. The evaluator recommended proceeding with lumbar surgery.

On 7-11-08, MD., reviewed the post CT myelogram of the lumbar spine dated 5-7-08. The evaluator noted that the L5 level showed slight asymmetry of the lamina thought to be post laminectomy defect. The L5-S1 interspace is slightly narrowed and there is mild facet sclerosis at this level. A moderate and symmetric bulge is present at this level. The neural foramina appear slightly compromised by the nerve root show no displacement or impingement. At the L4-L5 level, the interspace is markedly diminished and there is end-plate oburation. Mild facet sclerosis is demonstrated. There is mild symmetric annular bulging at this level without focal disc protrusion, significant narrowing of the neural foramina or nerve root displacement. The L1-L2, L2-L3 and L3-L4 levels are normal.

Follow up with Dr. notes the claimant continues with increasing pain, which is increasingly debilitating her. The claimant is refusing any oral medications now. The claimant is requesting interventional treatment. The claimant was offered lumbar trigger point injections followed by Lidoderm patches.

On 8-14-08, the claimant was evaluated by MD., who reviewed the lumbar myelogram and recommended facet blocks.

On 8-25-08, MD., performed a Peer Review. The evaluator reported that there were no objective, functional measures to warrant the trigger point injections provided.

On 9-10-08, the claimant underwent right L4-L5 transforaminal epidural steroid injection and trigger point injections.

The claimant continued to follow-up with Dr. who provided the claimant with Vicodin 5/500 mg.

A second surgical opinion performed by, MD., on 12-8-08 notes the claimant had evidence of L4-L5 HNP with radiculopathy and underlying instability. The evaluator noted the claimant's options were living with this versus possible surgical intervention. The claimant noted she had improvement with conservative treatment. The evaluator recommended obtaining a lumbar MRI.

Follow-up with Dr. dated 12-19-08 notes the claimant is having significant back pain radiating to her right buttock and right posterolateral leg to her lateral calf. On exam, the claimant has positive SLR at 45 degrees. She had decreased sensation at L4-L5 and 4+/5 EHL and dorsiflexion on the right side. At this time, the claimant is desirous of surgical intervention. The evaluator recommended a lumbar discogram/CT scan at L4-L5 and L5-S1.

Medical records reflect the claimant began a course of chronic pain management from 1-26-09 through 2-9-09.

There is a preauthorization request for EMG/NCS of the lower extremities dated 3-2-09.

3-5-09 DO., provided an adverse determination. The evaluator noted that there was no objective evidence of radiculopathy in the findings documented by Dr. that are corroborated by other notes. Therefore, the request for repeat H reflex test bilateral lower extremities x 2, EMG of bilateral lower extremities x 4 and sensory nerve conduction test bilateral lower extremity x 2 was denied.

Appeal from Dr. for reconsideration for repeat bilateral lower extremity needle EMG/NCS dated 4-8-09. The evaluator noted the claimant has progressive weakness and numbness in the right leg and increasing difficulty with bladder dysfunction. The evaluator noted the claimant's exams have noted reflex asymmetries as well as a reduced right knee jerk, as well as sensory and motor examination. Her MRI scan has

shown bilateral neuroforamina compression at L4-L5 and significant right sided foraminal disc herniation at L5-S1 level. The claimant has progressive changes indicating worsening of her radiculopathy and is being strongly considered for surgical intervention. A repeat study is felt to be medically indicated and necessary in order to determine the severity of her progression.

4-14-09 MD., provided an adverse determination. The reviewer reported the claimant has been evaluated with MRI and electrodiagnostic testing, evaluation by a spine surgeon followed by a negative CT myelogram. The request for duplicative, circular plan of evaluation/treatment, not evidence based.

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

The last requestor gives good clinical documentation for radiculopathy. ODG states if radiculopathy present EMG/NCS are not indicated. Therefore, the request for 95934 Repeat H reflex test bilateral lower extremities x 2; 95903 repeat EMG bilateral lower extremities x 4; 95904 repeat sensory nerve conduction studies bilateral lower extremities x 2 is not certified.

ODG-TWC, last update 4-29-09 Occupational Disorders of the Low Back – 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 EMG's 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) EMG's 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- 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)**