



Notice of Independent Review Decision

DATE OF REVIEW: 11/6/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for bilateral lower extremity electromyogram/nerve conduction velocity (EMG/NCV) studies.

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

Texas licensed Occupational Medicine Physician.

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.

The previously denied request for bilateral lower extremity EMG/NCV studies.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 10/20/09.

- Determination Letter dated 10/19/09, 9/30/09.
- Physician Advisor Report dated 10/16/09, 9/30/09.
- Follow-Up Office Visit Letter dated 9/4/09, 8/6/09.
- Medical Examination Letter dated 8/19/09.
- Medical Necessity Letter dated 7/1/09.
- MRI Report/Note dated 6/15/09.
- Encounter Summary dated 5/22/09.
- Lumbar Spine MRI dated 5/13/09.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Slip and fall

Diagnosis: Lumbar strain, status post fusion L3-S1, failed back syndrome.

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

The claimant, a female, was being treated for an injury that she sustained on xx/xx/xx, from a trip and fall. She saw Dr. on 05/22/09 and she complained of recurrent low back and leg pain. She had last been seen in 2006 and reported driving. Her legs went numb and felt weak. Lying down helped her pain. She had numbness and tingling in both legs. Her pain was described as constant, achy and was rated at 8/10 level on a pain scale. She had "Valsalva changes." She was taking Darvocet and Lodine. Dr. diagnosed a re-exacerbation of her back pain. She was status post L3-4, L4-5 and L5-S1 fusion. She had facet joint hypertrophy and ligamentum flavum hypertrophy at several levels on an MRI (05/13/09). The diagnosis was failed back syndrome. Dr. recommended a Medrol dosepak. She was placed on restricted work. She stated that she dragged her left leg. An EMG was ordered to rule out acute vs. chronic radiculopathy. ESI was also recommended. In a letter dated 06/15/09, Dr. stated the claimant had significant changes on her MRI and that the changes were likely related to her injury in xx. On 07/01/09, he recommended the ESI again. On 08/06/09, she still complained of lumbar back pain into her right gluteus and down both legs. Sitting and standing too long made her symptoms worse. She had numbness and tingling and some weakness. She was tripping a lot. She had 2+ bilateral lower extremity reflexes, strength 3/5 of right plantar and dorsiflexion. Sensation to pinprick was slightly hypoesthetic in the L5 dermatomal pattern. Seated straight leg raise was positive at 60 degrees bilaterally for bilateral gluteus pain. Valsalva's maneuver was positive. There was severely restricted active range of motion (AROM) noted. The EMG and ESI had been denied. She was working full duty. A Required Medical Examination

was completed on 08/19/09 by Dr. and she was reportedly injured when she slipped and fell. She had ESIs in the past and was described as at maximum medical improvement (MMI) on 07/29/04. She was status post fusion with acute motor radiculopathy at L5-S1 on the right and chronic left motor radiculopathy at L5. She had an antalgic gait and was in mild distress. She was obese. She had restricted range of motion without pain; deep tendon reflexes were intact; negative straight leg raises and some tenderness. She had good heel and toe walk and strength was 5/5 in the bilateral lower extremities. Sensory testing was intact. There was no evidence of radiculopathy on physical examination. She has degenerative disc disease (DDD) and/or age-related changes that were thought to be causing her symptoms. Additional medical treatment was not recommended. He recommended over-the-counter (OTC) medications only. He recommended an aggressive exercise program and weight loss. On 09/04/09, Dr. stated he did not feel she was at MMI. The history and documentation submitted for this review did not clearly and objectively support the request for an EMG/NCV at this time. The claimant had chronic pain status post treatment, including surgery, for her low back injury. There was no documentation of neurologic symptoms or findings for which another EMG can be recommended. There was no documentation of objective findings demonstrating the presence of radiculopathy or peripheral nerve compression. There was no indication that the claimant had been doing regular exercises since her surgery. The medical necessity of re-evaluation by EMG has not been demonstrated and is not supported by the ODG which state "EMG may be 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." There was little justification for performing EMG/NCV in this case. The claimant had chronic pain, but no evidence of a structural or neurologic condition for which an EMG is likely to significantly change her treatment.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines, Work Loss Data Institute, 2009. Low back-EMG studies

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).