



Notice of Independent Review Decision

DATE OF REVIEW: 7/15/10

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCS bilateral lower extremity

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

Certified by the American Board of Family Practice

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.10	95900	Upheld
		Prospective	722.10	95900	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Determination letters dated 6/25/10, 6/17/10
- Physician/practitioner notes/consultation from 9/14/09 through 6/8/10
- Electrodiagnostic evaluation dated 1/11/08
- X-ray reports dated 9/17/09, 7/10/09
- Operative report dated 9/17/09
- Physical therapy note dated 10/7/09

PATIENT CLINICAL HISTORY:

The patient is a male whose date of injury is xx/xx/xx. Records indicate the patient slipped off a ladder and injured his lower back. The patient underwent multilevel decompression at L3-4, L4-5 and L5-S1 in May 2008. Revision surgery was performed 09/17/09. The patient was seen in follow-up on 12/14/09 status post revision decompression of L3-4, L4-5 and L5-S1 with bilateral partial laminectomy L3, total L4 laminectomy, and bilateral L5 laminectomy performed 09/17/09. The patient notes he continues with lower back pain as well as left leg discomfort. He states it is better than prior to surgery; however, he is still requiring 2-3 Norco a day, Flexeril, Lyrica, as well as Mobic. He continues with slight swelling in bilateral lower extremities but nothing as severe as prior to surgery. The patient has been through physical therapy as well as functional capacity evaluation. He is working with DARS to try and get some retraining done. Physical examination at that time reported the patient to be 5'8" tall and 280 lbs. The patient was able to ambulate without assistance. The patient has normal gait. He is neurologically intact. Sciatic tension was negative. Progress note dated 04/20/10 indicates the patient still complains of significant low back pain and left leg dysesthesias. Objective findings reported symmetric reflexes of knees and ankles. Sitting root test is negative on both sides. Muscle strength is 5/5. MRI

of the lumbar spine was reviewed and noted to show disc desiccation from L2-3 down to L5-S1. Disc is stable at L3-4, central and right sided again at L4-5 level and L5-S1 is unremarkable. On post gadolinium films there is enhancement seen particularly at L3-4 level with only what appears to be mild central protrusion, but the thecal sac is compressed, and again on L4-5 level there is gadolinium enhancement that is scar tissue on right side and nothing on left. The patient was noted to have EMG/NCV study in January 2008, but nothing since then and has had two surgeries since that time. The patient was seen in follow-up on 06/08/10, and swelling in his leg was noted to be a little better today but did not notice any improvement after he stopped Topamax when last seen on 05/18/10. The patient stated swelling persisted for a couple of weeks despite stopping the Topamax. The patient had only 1-2+ peripheral edema on this date, significantly less than it was. The patient was noted to still have decreased sensation in the lateral aspect of the left leg. Reflexes are equal. Sitting root test is negative. The patient was recommended to have EMG studies since he has had two surgeries since previous EMG studies 2 ½ years ago, and repeat studies were noted to be helpful to see if the patient has chronic denervation or if anything acute going on.

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

In the Reviewer's opinion, based on the clinical data presented, medical necessity was not established for EMG/NCS of bilateral lower extremities. The patient sustained an injury to the low back on xx/xx/xx when he slipped off of a ladder. After failing a course of conservative care including medications, physical therapy and epidural steroid injections, the patient underwent multilevel decompression at L3-4, L4-5 and L5-S1 performed 05/15/08. A revision surgery was performed on 09/17/09 with decompression of L3-4, L4-5 and L5-S1. The patient underwent a course of postoperative therapy, but continued to report low back pain and left leg pain. The patient continued with left leg dysesthesias, unchanged from 11/09 until follow up in 06/10. According to the Reviewer, ODG does not support electrodiagnostic testing when radiculopathy is clinically evident. Also, it is noted that there has been no significant change in clinical presentation from 11/09 until 06/10. The proposed studies will not advance the diagnosis or alter the treatment plan. Given the current clinical data, medical necessity was not established for EMG/NCS of the bilateral lower extremities.

References:

The 2010 Official Disability Guidelines, 15th edition, The Work Loss Data Institute. Online edition. Low Back Chapter

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 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.)

Nerve conduction studies (NCS)

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.

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)