INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 12/07/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal EMG/NCV BLE 95861, 95904, 95903-f-wave, 95934

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

Texas Board Certified Orthopedic Surgeon
Texas Board Certified Orthopedic Sports Medicine

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 04/08/98 - Operative Report
2. 02/27/09 - Clinical Note - MD
3. 12/10/09 - MRI Lumbar Spine
4. 01/05/10 - Clinical Note - MD
5. 03/03/10 - Operative Report
6. 03/16/10 - Clinical Note - MD
7. 04/15/10 - Clinical Note - MD
8. 05/13/10 - Clinical Note - MD
9. 06/10/10 - Clinical Note - MD
10. 06/29/10 - Clinical Note - MD
11. 07/08/10 - Clinical Note - MD
12. 08/05/10 - Clinical Note - MD
13. 09/02/10 - Clinical Note - MD
14. 09/24/10 - MRI Lumbar Spine
15. 09/28/10 - Clinical Note - MD

16.10/22/10 - Utilization Review
17.10/28/10 - Letter - MD
18.11/08/10 - Utilization Review
19.**Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an unknown injury on xx/xx/xx.

The employee underwent laminectomy of L3-L4, L4-L5, and L5-S1 with medial one-third facetectomy of the L3-L4, L4-L5, and L5-S1 facet joints and bilateral subarticular and foraminal decompression of the L4, L5, and S1 nerve roots on 04/08/98.

The employee saw Dr. on 02/27/09. The employee reported low back pain with intermittent radiation down the legs. The employee followed a home exercise program which seems to help. Current medications included Lortab and Soma. Physical examination revealed the employee to be neurologically intact. Straight leg raise was negative. The employee was assessed with lumbar disc herniation at L4-L5 an L5-S1 status post decompression and grade I spondylolisthesis at L4-L5 with post-laminectomy syndrome. The employee was recommended to continue his home exercise program. The employee's medications were refilled.

An MRI of the lumbar spine performed 12/10/09 demonstrated Grade 2 anterolisthesis of L4 and L5. There was compression of both L4 and both L5 nerve roots at the L4-L5 level due to anterolisthesis and broad-based disc herniation. At L5-S1, there was a right paracentral disc herniation with compression of right S1 nerve root and mild compression of both L5 nerve roots.

The employee saw Dr. on 01/05/10. The employee continued to experience low back pain that radiated down the lower extremities, right greater than left. The employee reported numbness and tingling in the dorsal aspect of the right foot. The pain worsened with prolonged standing or walking. Physical examination revealed tenderness over the right iliac crest and over the right sciatic notch. Straight leg raise was positive on the right at 75 degrees, reproducing buttock, thigh, and calf pain. There was decreased sensation of the right lateral calf and dorsal foot. Dorsiflexion of the right foot increases pain. The employee was assessed with post laminectomy syndrome, recurrent right disc herniation at L5-S1, and right greater than left lumbosacral neuritis/radiculopathy. The employee was recommended for surgical intervention.

The employee underwent redo bilateral laminectomy of the L4-L5 segments with medial one-third facetectomy, bilateral L5-S1 segments with medial one-third facetectomies, L4-L5 disc excision with posterior lumbar interbody fusion using local bone graft, Fortis bone instrumentation, posterolateral intertransverse fusion of L4-L5 with local bone graft, and Silverton pedicle screw instrumentation of L4-L5 with crosslink on 03/03/10.

The employee was seen for follow up on 03/16/10. The employee reported incisional pain and tingling in the bilateral feet. Physical examination revealed some irritation

around the staples. There was no incisional drainage. Radiographs of the lumbar spine demonstrate the bone graft to be in good position at L4-L5. The spondylolisthesis was reduced. The pedicle screw instrumentation was intact. The employee was recommended to gradually increase walking.

The employee was seen for follow up on 04/15/10. The employee stated his preoperative leg pain was better and the incisional pain was improving. Physical examination revealed a well-healing incision with no signs of infection. Radiographs demonstrated the bone graft in good position and the instrumentation intact. The employee was released to light duty. The employee was prescribed Norco and Robaxin.

The employee saw Dr on 06/29/10 with complaints of increased pain. The employee noted spasms in the right side of the low back. The employee denied fever, chills, or headaches. The employee denied any symptoms down the legs. The employee did report nausea at night. Physical examination reveals a flat incision with no swelling or signs of infection. Neurologically, the employee was intact to both lower extremities with good motor strength. The employee was given a Toradol injection and was sent for laboratory work.

The employee was seen for follow up on 07/08/10. The employee stated he felt better. Laboratory results show a mildly elevated sedimentation rate of 25 and a mildly elevated white count of 13.6. Physical examination revealed a flat incision with no signs of infection or drainage. The employee was advised to continue his home exercise program.

The employee saw Dr. on 09/02/10. The employee reported difficulty walking without the support of a cane. The employee complained of pain in the back, buttock, and legs, particularly on the right side with walking. The employee stated he did not have much stability in the legs. Physical examination revealed a markedly positive Trendelenburg gait with weakness on the right. There was 4/5 strength in both feet dorsiflexors. There was trace reflex of the left knee and 1+ response of the right knee. There are no beats of clonus. Radiographs demonstrate a solid interbody fusion at L4-5. The pedicle screws were intact. The adjacent levels were unremarkable. The employee was assessed with new onset marked weakness in both legs, particularly on the right side with weakness of the pelvic girdle musculature and dorsiflexors of both legs. The employee was recommended for MRI of the lumbar and thoracic spine.

An MRI of the lumbar spine performed 09/24/10 demonstrated postoperative laminectomy changes of L4-S1 with hardware placement at L4-L5. There was no evidence of recurrent central canal stenosis. There was Grade I anterolisthesis at L4-L5. There was moderate spinal stenosis at L3-L4 with a small to moderate broad-based protrusion and moderate facet hypertrophy. There were small to moderate disc

protrusions at multiple levels along with multilevel neural foraminal narrowing, fairly severe on the right from L3 through S1 with lesser amount of narrowing at multiple levels on the left side. There was no additional central canal stenosis identified.

The employee saw Dr. on 09/28/10. The employee complained of back pain with radiation down both legs. The employee reported difficulty with prolonged sitting or standing due to pain, numbness, tingling, and weakness. Physical examination revealed decreased sensation in the left lateral calf. There was good range of motion of the hips. There were some diminished knee jerk reflexes bilaterally. There was decreased sensation in the lateral calf area bilaterally. The employee stands and walks with his feet flexed. The employee was assessed with status post bilateral decompression of L4-L5 and L5-S1 with L4-L5 fusion and stabilization with instrumentation and adjacent level disc herniation at L3-L4 with secondary stenosis. This did compress the thecal sac and exiting nerve roots and would correlate with his back and bilateral radicular symptoms. The employee was recommended for electrodiagnostic studies.

The request for EMG/NCV of the bilateral lower extremities was denied by utilization review on 10/22/10 as current guidelines do not recommend the use of electrodiagnostic studies for a clear diagnosis of nerve impingement if subjective and objective findings suggest obvious radiculopathy. The exhaustion of recommended conservative therapies, such as medications and physical therapy, and the response was not objectively documented. The reported injury date is over fifteen years ago, and it was unclear if the findings noted clinically represent a status change or the status quo for this employee, particularly from a neurologic perspective. It was not clear how results of the requested studies may lead to treatment that will reasonably/expectedly bring about significant changes in the employee's overall function.

The request for EMG/NCV of the bilateral lower extremities was denied by utilization review on 11/08/10 as evidence-based guidelines do not support F-wave tests or electrodiagnostic studies when radiculopathy was already clinically obvious or when an employee is presumed to have symptoms on the basis of radiculopathy.

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

The requested electrodiagnostic studies would not be considered medically necessary based on the clinical documentation provided for review. The most recent clinical documentation demonstrates objective evidence of lumbar radiculopathy that appears fairly stable with no significant changes noted. Guidelines do not recommend EMG, NCV, or F wave studies when there is clinical evidence on examination consistent with lumbar radiculopathy. The employee's pathology in the lumbar spine is clearly defined, and it is unclear how EMG, NCV, or F wave studies would provide any additional clinical

information that would reasonably guide the employee's course of therapy. As such, the requested electrodiagnostic studies are not supported by the clinical documentation as medically necessary.

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

Official Disability Guidelines, Online Version, Low Back Chapter