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Notice of Independent Review Decision

DATE OF REVIEW: 06/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV bilateral upper extremities, 99244 x 1 unit, 95861 x 1unit, 95903 x 6 units and 95904 x 6 units.

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

The physician providing this review is a Doctor of Chiropractic. The reviewer is certified by the National Board of Chiropractic Examiners.

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits (09/24/03 - 04/29/10)
- Diagnostics (09/22/03 – 03/08/10)
- Procedures (09/24/03)
- Therapy (11/11/03 – 04/16/04)

Dr.

- Office visits (02/23/10)
- Diagnostics (03/08/10)

- Pre-authorization request (05/06/10 – 05/11/10)
- Utilization review (05/11/10)

TDI

- Utilization review (05/11/10 – 05/26/10)

- Carrier Submission (06/07/10)

ODG have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx, when he was a passenger on the back of a tractor. The driver changed in to an incorrect gear causing the pole or mast of the tractor to fall and strike him who then fell off of the tractor on to his back.

2003 – 2004: In August 2003, M.D., noted that the patient's condition had aggravated as he had undergone treatment with needles in the spine and developed pain radiating all the way into the bottom of his foot on the left with associated numbness. In September, the patient underwent x-rays of chest that revealed cardiomegaly and minimal bibasilar linear discoid atelectasis. Dr. saw the patient for severe lower back pain radiating to the left leg, not improved with conservative measure. He reviewed MRI dated July 2002, which revealed L5-S1 herniated disc and new MRI confirmed the pathology and the disc appeared to be herniated, worse then before. Dr. performed left L5-S1 micro-hemilaminectomy, discectomy and foraminotomy. Postoperative x-rays of the lumbar spine revealed metal probe posterior to the L5-S1 interspaces. The patient attended therapy at Health Care and Rehab Center consisting of hot or cold pack, electrical stimulation, ultrasound, vibratory massage, therapeutic procedures and Biofreeze through April 2004.

In a functional capacity evaluation (FCE) dated December 5, 2003, the patient qualified at light to medium physical demand level (PDL) versus heavy PDL required by his job. The evaluator recommended work hardening program (WHP).

Blood studies revealed glucose of 356. Urinalysis revealed spilling of 100 mg of glucose per ml. Dr. gave trials of Soma and Ultram for pain, and later changed it to Darvocet-N 100 and Flexeril. In October, Dr. noted absent knee and ankle reflexes and obtained MRI of lumbosacral spine that revealed status post left hemilaminectomy at L5-S1 with 2-3 mm broad disc protrusion displacing the left S1 nerve root anteriorly and bilateral foraminal stenosis. There was some peripheral soft tissue component suggestive of scar tissue.

2005-2009: No records are available.

2010: In February, D.C., saw the patient for lower back pain and stiffness with tingling and weakness from the left lumbar spine to the bottom of foot. History was positive for type II diabetes and dyslipidemia. Examination revealed 3 inch midline lumbar healed surgical scar formation from L3 through L5, percussion elicited a pain in response to deep palpation from L5 through S1 level and muscle spasms were palpable bilaterally in the lumbar spine. Farfar's torsion and Kemp's torsion test were positive for increased lower back pain. Dr. assessed status post lumbar spine decompression, failed lumbar surgical syndrome and muscle spasm. He noted that the patient was examined by M.D., for a required medical evaluation (RME) and was recommended to undergo another lumbar MRI, lumbar flexion and extension views to see segmental instability and was recommended medications including Ultram and Neurontin.

X-rays of the lumbar spine revealed poor movement of the lumbar spine in the flexion and extension views consistent with muscle spasm and post surgical left hemilaminectomy changes of the L5-S1 levels. There was a subtle subluxation of L3 relative to L4 minimally worse on flexion and moderate spondylosis at L5-S1 and mild spondylosis at T12-L1 with small ventral disc osteophyte complex projecting towards the prevertebral space. MRI revealed post surgical changes at L5-S1, post surgical fibrotic scarring on the left partially obscuring the left S1 nerve root and posterior protrusion-subligamentous disc herniation at this level measuring 3.0 to 3.7-mm and posterior bulging disc at L4-L5.

In April, M.D., a pain management physician, saw the patient for low back pain with associated left leg pain. He noted that maximum medical improvement (MMI) occurred on June 16, 2004, with a 5% whole person impairment (WPI) as per Dr.. Surgical history was positive for percutaneous discectomy/neuroplasty, left L5-S1 with post injections of steroid in December 2002. Examination showed ability to flex lumbar spine from a standing position to around 45 degrees and extend to about 50 degrees, tenderness of lumbar paraspinal musculature, midline vertical surgical scar in lumbar spine regions and production of lower back pain with seated straight leg raising (SLR). Dr. diagnosed low back pain and surgical intervention-lumbar laminectomy and recommended continuing medications and scheduled the patient for surgical evaluation of the lumbar spine. He recommended consideration for chronic pain management program (CPMP).

On May 6, 2010, Dr., requested electromyography/nerve conduction velocity (EMG/NCV) study of lower extremities since he had lower extremity neuropathy and lower radicular symptoms with motor and sensory, multiple positive orthopedic and neurological findings and positive subjective and objective findings.

Per utilization review dated May 11, 2010, request for EMG/NCV bilateral lower extremity 99244, 95861, 95903 and 95904 was denied with following rationale: *"The patient is complaining of low back pain that radiates to the left lower extremity. A letter of medical necessity request electrodiagnostic studies as the patient has multiple neurologic findings with motor weakness and sensory deficits. The current guidelines do not support electromyography and nerve conduction velocity when radiography is already clinically obvious. The physical exam submitted showed motor strength weakness and decreased reflexes which would be findings consistent with radiculopathy. Therefore based on current guidelines, the request for EMG/NCV of the bilateral lower extremity is non-certified."*

Dr. appealed for EMG/NCV of bilateral lower extremities.

Per reconsideration review dated May 26, 2010, appeal for EMG/NCV of bilateral lower extremities 99244, 95861, 95903 and 95904 was denied with following rationale: *"The patient appears to have classic lumbar radiculopathy. He has neurological deficits in a dermatomal distribution. There is no justification or rationale for repeat testing at this time. Dr. was unable to discuss treatment options with the attending doctor."*

Carrier submission summary dated June 7, 2010, indicated the following: (1) The requested EMG/NCV bilateral lower extremities 99244, 95861, 95903 is not medically indicated and not supported by the documentation submitted. (2) The request exceeds the standards of evidence-based medicine set out in Texas Labor Code and Administrative Code as limitations for appropriate healthcare for the compensable injury of xx/xx/xx. (3) As stated in UTA's initial determination and reconsideration appeal denial rationale, the prospective request is medically unnecessary. (4) The request for EMG was submitted for approval in April of this year and was denied for the same reasons by URA Dr. and Dr.. Based on his physical exam, it is not necessary to have the electrodiagnostic studies. (5) The carrier is responsible for medical benefit as a result of the compensable injury only. The carrier is not responsible for treatment as a result of ordinary diseases of life.

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

Based on the records, it appears to be apparent that the patient has lumbar radiculopathy. The EMG/nerve conduction study does nothing to change the diagnosis or provide direction for treatment. EMG/nerve conduction studies are not therapeutically beneficial. There were no objectively measurable gains from the EMG/nerve conduction studies to support the need or medical necessity.

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**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**