URAC ACCREDITED

CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 3-1-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

EMG/NCV lower extremity 95860-95900-95861-95903-95904-95934

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

American Board of Orthopaedic Surgery-Board Certified

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

- 6-27-03 MD., performed a Required Medical Evaluation.
- 4-12-04 MD., performed a Required Medical Evaluation.
- 3-8-06 MD., office visit.
- 12-16-09 MD., office visit.
- 12-31-09 Utilization Review.
- 1-13-10 MD., provided a letter.
- 1-21-01 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

6-27-03 MD., performed a Required Medical Evaluation. It was his opinion that this claimant suffered no more than a soft-tissue injury to the axial spine on xx/xx/xx. The evaluator was in agreement with Drs. and that the claimant was at MMI shortly after the injury. He did not feel the surgery and all subsequent care was medically reasonable or necessary. This care, however, has been accepted and the claimant now suffers from chronic neck and back pain with no clear source for this pain. In his opinion, the original and compensable injury essentially resolved 3-4 months after the injury. This claimant has no clear and identifiable source for his current complaints beyond illness behavior without any clear anatomic correlation for this behavior. Current treatment appears aimed at a physical solution to this psychological condition and will continue to fail. The only diagnosis that the evaluator could relate to the injury of xx/xx/xx is a sprain/strain of the cervical and lumbar spines. NSAID, which could be over the counter ibuprofen, a muscle relaxant, such as Robaxin and a mild analgesic such as, Ultram or Darvocet would be appropriate.

4-12-04 MD., performed a Required Medical Evaluation. The claimant presented to the office for the purpose of a required medical evaluation. At that time, the claimant explained that he was 39 years of age. He further explained to me that he had been involved in a work-related injury on xx/xx/xx. At that time, he had finished drilling through the wall. He had put his drill back down on the floor. He tried to pick himself up from the seated position. He had his right hand on a sprinkler system and his left hand on the top of the wall. As he tried to pull himself up, he felt an electrical shock. He was temporarily paralyzed from the electrical current. He subsequently had complaints of low back pain. He came under the care of Dr. Dr. recommended surgery, and this was

undertaken in 1995. At that time, he underwent an L3 to S1 fusion. Subsequent to that, he has been treated with ongoing medication, ongoing physical therapy, ongoing aquatics, and has had a variety of ongoing evaluations for his continued low back pain, mid back pain, and neck pain. At the time of my evaluation, he stated that his major complaint continued to be low back pain. This was not associated with any particular complaint. He also continued to complain of mid back pain. He said that he could feel a popping if he took a big breath inwards. He also had some headache and associated neck stiffness. He said that his treatment varies between therapy and medications. His current medications include Soma, Vicodin, and Etodolac. His low back exam showed midline incision. This was well healed. There was tenderness even to the most superficial palpation. His range of motion was limited to 10 degrees of flexion and 10 degrees of extension. This was limited by pain. In the seated position, he had no pain with straight leg raising. He had normal strength in the iliopsoas, quads, tibia and EHL, gastroc, and soleus group. He had normal reflexes at the knees and ankles. Examination of his mid back shows pain to superficial palpation. He had pain with inspiration and expiration. There was no evidence of any myelopathy, spasticity, or long-tract sign. Examination of the neck showed that he had axial rotation of about 45 degrees to the right and left side. He had no pain with head compression. He has some tenderness to palpation of the sternomastoid and trapezius muscles. He had normal motor power in both upper extremities. There was a negative Hoffman sign. Specifically, it is his opinion that the claimant does not require any further surgical treatment either to the necessary, mid back, or low back. Specifically, the evaluator was of the opinion that there is no evidence that the claimant has any ongoing symptoms referable to his hardware and that he personally would not recommend any hardware or implant removal. It was his opinion, as indicated above, that hardware removal is unnecessary and unreasonable at this time. It was his opinion that no further treatment recommendations are necessary. The evaluator should note that he personally reviewed a variety of imaging studies that he brought. These include a myelogram and post myelogram CT dated 11-16-01. These did not show any evidence of any nerve root or spinal cord compression. The evaluator personally reviewed CT discograms of the cervical spine dated 3-6-02. These did not show any distinct surgical abnormality. He personally reviewed a lumbar myelogram and post myelogram CT. These are dated 4-9-99. The CT scan shows a solid fusion. There is no evidence of any implant loosening. There is no evidence of any ongoing nerve root compression. There is no evidence of any spinal stenosis. It was his opinion that this man's current medications do not and are not necessary on a long-term basis. Specifically, it was his opinion that the continued use of Vicodin is unreasonable and unnecessary. Vicodin is a narcotic and not recommended for chronic use. It was his opinion that over the next two or three months he could be weaned from the narcotic prescription medication to over-the-counter pain medication. It is further his opinion that Soma has been recognized to be habituating. It is not recommended for long-term use. It was his opinion that over the next two to three months the claimant could be weaned from Soma and again transferred to over-the-counter medication. It is well known that Etodolac on an ongoing, long-term basis has potential hepatic and renal side effects. It was his opinion that over the next two to three months this claimant could be weaned from Etodolac and be

transferred to over-the-counter medications such as Motrin and Advil. It was his opinion that over the next two to three months prescription medications be weaned.

On 3-8-06, the claimant was evaluated by MD. The evaluator reported that the claimant's current diagnosis is status spot lumbar fusion. It was his opinion that the effects of the original injury has resolved. Specifically, he felt the claimant did not require any further surgical treatment in the mid or low back. It was evident that the claimant had ongoing symptoms referable to the hardware. However, he felt that surgery was not necessary. It was his opinion that epidural steroid injection were not necessary. Clearly he did not require formal treatment of any sort.

12-16-09 MD., the claimant is seen in follow up. The claimant has been seen by Dr. who attempted to do an evaluation, but apparently it was denied. Dr. is not willing to continue to work with the claimant. The claimant reports continue lumbar pain that has been getting progressively worse since the last visit. The pain radiates down the bilateral lower extremities. He reports numbness in his genitalia as well as down the posterior thigh to his knees. The numbness occasionally will extend as far as the soles of his feet. The claimant has been having increasing difficulties with ADL's. On exam, the claimant changes positions frequently through the course of the visit. Range of motion is limited at the lumbar spine with pain. Palpation is positive for pain at approximately L2 through L5 and in the sacral area. SLR is positive bilaterally at approximately 30 degrees for tingling along the posterior thighs and calves. Motor exam is normal. Sensory exam is positive for numbness along the posterior thighs bilaterally but does not extend past the knee. Assessment: Lumbar intervertebral disc disease and lumbar radiculopathy status post surgery. The evaluator reported it is obvious that his injury in xxxx was followed up by an MRI in February 2005, less than 3 months after the original injury, which showed lumbar disk herniations. He subsequently underwent surgery for these disk herniations. At this time, the primary consideration is long-term complications of the lumbar surgery. It appears that the evidence indicates that his original injury was not merely a strain but a lumbar disk herniation and that he continues to have radicular symptoms that are related to this injury. Specific characterization and objective findings related to this injury are imperative. Therefore, the evaluator requested again EMG/NCS to evaluate the presence of radiculopathy in an objective fashion. He is to follow up at the first available appointment after the study is done with the intention that if it does show objective evidence of radiculopathy, then he will be re-referred to a spine surgeon. At this time, the evaluator refilled his pain medications. He is complaining that the Flexeril is making him sleepy so we will change this to Methocarbamol 750 mg 2 tablets b.i.d, Continue Vicodin 5/500 one tablet p.o. q.6 h. p.r.n. pain. Continue sodium decussate 100 mg 1-2 p.o. p.r.n. constipation related to the constant use of Vicodin. Biofreeze to apply b.i.d., 32 ounces.

12-31-09 Utilization Review. The claimant had a work injury in xxxx and had subsequent surgery to include fusion. The claimant has been evaluated by another spine surgeon who found no need for further diagnostics including the need for an EMG/NCS. Moreover, this type test does not provide any anatomical analysis of the spinal canal. The request is not approved as medical necessity.

1-13-10 MD., provided a letter. The evaluator reported that the claimant has been under his care and he had referred him to Dr. for further treatment. Dr. requested the EMG and it ws denied on 10-19-09. The evaluator reported he requested the EMG on 12-16-09. This EMG was denied again on 12-31-09. This test was ordered toy provide objective evidence of radiculopathy in determining whether surgery is indicated for the claimant. The evaluator reported that while the EMG does not directly cover the spinal cord, it does provide indication of the effects of spinal impingement of the discs on the nerve roots with the functions of the affected nerves.

1-21-01 MD., performed a Utilization Review. The request for EMG/NCS is not medically necessary at this time. Clinical documentation submitted for review indicates the claimant underwent an independent medical evaluation in which it was recommended that the claimant no longer requires ongoing treatment. The note specifically recommends that the claimant does not require an EMG study. As such, the medical necessity for the request for EMG/NCS of the lower extremity has not been established at this time.

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

FOLLOWING REVIEW OF THE AVAILABLE MEDICAL RECORDS, THERE IS A LACK OF OBJECTIVE EXAM FINDINGS TO SUPPORT CLAIMANT'S SUBJECTIVE COMPLAINTS OF BACK AND LEG PAINS.

THE USE OF AN EMG/NCV TO TRY TO SHOW A RADICULOPATHY IS QUESTIONABLE. THERE ARE SUBJECTIVE SYMPTOMS WITH NO EXAM FINDINGS. THE PRESENCE OF EMG CHANGES DOES NOT JUSTIFY PROCEEDING TO SURGERY OF THE LUMBAR SPINE. THEREFORE, THE REQUEST FOR EMG/NCV OF THE LOWER EXTREMITY IS NOT MEDICALLY NECESSARY.

ODG-TWC, last update 2-23-10 Occupational Disorders of the Low Back – Electrodiagnostic testing:

Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:

(1) EDX testing should be medically indicated.

(2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable.

(3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.

(4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.
(5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.
(6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.
(7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)

Electromyogram: 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.

Nerve conduction studies: 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)**